

THE MEDICAL AND SURGICAL REPORTER.

No. 1485.]

PHILADELPHIA, AUGUST 15, 1885.

[Vol. LIII.—No. 7.]

ORIGINAL DEPARTMENT.

COMMUNICATIONS.

DIAGNOSIS AND TREATMENT OF DENTRITIC CYSTIC TUMORS OF THE JAWS.

BY JOHN S. SMITH, D. D. S.,
of Lancaster, Pa.

Diagnosis.—Cystic tumors may be confounded with other affections which occasion swellings about the jaws, as enchondromata, sarcomata, and myxomata, abscesses, and the collections of fluids in the antrum. Dental alveolar abscess may be distinguished by its acute course, and when in a chronic condition by the discharge of its contents through the fistula, either upon the gum, or within the oral cavity. The tumor formed by an abscess is never so sharply defined as is the case with cysts; with dropsy of the antral cavity the distention of the facial wall of the jaw is more uniform than it is with cysts.

In some cases of cystic tumors, they present so formidable an appearance at first sight, that they may be taken for solid tumors; especially is this so when their walls are compact and well organized, nearly if not altogether obliterating the sense of fluctuation when pressure is made upon them.

Cases have come under the observation of the writer where it required the most delicate touch to detect any fluctuation when pressure was made upon the apex of the tumor.

In some cases the diagnosis cannot be determined accurately until after one or more teeth are removed that are involved with the tumor. After such operation, a probe carried through the alveolus will usually reveal the true condition of the lesion. One or more dead teeth are found in-

volved—one, however, being the rule in most cases which have come to the notice of the writer, while two, and sometimes three, are implicated with the tumor. The dead tooth may be easily distinguished from the living ones by its opaque appearance. Such tooth may be carious, and it may not.

Primarily the dentritic cyst originates from what pathologists call a "cold abscess," that is, an abscess which has never opened; subsequently, having developed into a tumor. The interior of the cyst has a fibrous lining, and being compact in structure, is the seat of an inflammatory process. The cyst contains a puriform fluid; it may attain such magnitude as to invest several teeth and extend beyond the alveolar process. The tumor is usually oval in shape, with its apex on a line with the diseased tooth directly involved. The size of the tumor may be as large as a hulled walnut, or as small as a hazel-nut; crepitates under pressure, and feels like parchment. In cases of long standing, considerable resorption of the alveolar process takes place, and the teeth immediately connected will be loose; especially will this be the case if the alveolar borders are broken; these teeth should be removed. These tumors are found painless, as a rule. I have met with cases, however, where an acute inflammatory condition was present, with all the symptoms of acute periodontitis manifested. So that it could have been readily mistaken for the pointing of an alveolar abscess.

Pathology.—Cysts of the jaws may be either simple or compound; whether they be cysts of retention, exudation cysts, or extravasation cysts belonging to the jaws, is a matter not as yet fully

established. The exudation cyst is a secretory cyst; in a generic relation, however, it is just the opposite of the retention cyst. Serous sacs form the foundations of the exudation cysts. "The mode of development of cysts of the jaws," says Wedl, "has not yet been determined; it therefore becomes necessary, in order to throw more light on the subject, to pursue further anatomical investigations in that direction."

Rindfleisch says: "The accumulation of the fluid is not produced by the continuance of the normal secretion, but by an exudation surpassing the normal measure of the serum of the blood with salts, albumen, fibrinogenous substance, and extractives, in the most varying proportions. The exudation cysts have little to do with pathological new formation. Of extravasation cysts," he says, "a parenchymatous bleeding can very well be the point of departure for the formation of a cyst. The hemorrhagic depot can present itself primarily as a cyst, namely, when the blood is poured out between two surfaces in themselves smooth; for example, bone and periosteum, cartilage and perichondrium, and thereafter remains fluid. As a cyst may also be formed when upon the one hand the liminary parenchyma furnishes a connective tissue membrane, upon the other hand, the blood itself is resorbed through a series of metamorphoses up to a small remainder, and is replaced by a clear fluid."

The above-mentioned condition is liable to manifest itself within the body of the jaw, the bone and periosteum, after severe mechanical injuries to the bone, and the rupture of blood-vessels within the parenchyma. There can be little doubt that many of the so-called dentritic cysts of the jaws have their origin primarily from causes brought about by falls, strokes and mechanical violence, causing rupture of blood-vessels. It is quite true, history of cases fully confirms such facts.

Clinical observations lead us to believe, however, that only in cases where the abscess does not open, we find the pathological new formation taking place within the jaws. Pulpitis, and as has been observed, followed by pericementitis and periodontitis, is a prolific cause of the development of the dentritic cystic tumor.

Treatment.—The removal of all dead teeth involved. Other teeth whose pulps are living may be loose, and to a casual observer appear to be complicated, but a careful examination will reveal the fact that they should not be disturbed but retained in their places; only one tooth may be the offender, being a dead one which has caused the trouble. After the removal of the cause, let it be

either one or more dead teeth or fangs of teeth, cyst walls may be punctured with a sharp instrument, and the contents of the sac released, this being done by carrying the instrument through the alveoli, and not through the bony parietes of the jaw. After the contents of the sac is let out, and the sharp spicula of bone trimmed, with engine burrs, tincture of iodine full strength may be forced into the cyst sac, by saturating tufts of cotton-wool and allowing them to remain, again repeating the treatment at intervals of a day. If necrosis of bone be present, it is good practice to alternate the iodine treatment with aromatic sulphuric acid. Cases generally yield to this treatment in from six weeks to three months. I have seen cases not yielding to treatment for nine months. There are other and shorter methods in the treatment which perhaps some would prefer—the cutting down through the body of the tumor, by making a crucial incision and scraping out the contents of the sac, afterwards allowing nature to do the rest—but I do not believe it is the best or the safest way. There is surely a much greater loss of structure, which is never restored as in the former method by granulation, after the secreting cells have been destroyed by medicinal applications of iodine and sulphuric acid treatment.

TWO OVARIOTOMIES SUCCESSFULLY PERFORMED ON THE SAME PATIENT.*

BY JOSEPH RANSOHOFF, M. D., F. R. C. S.,
Of Cincinnati.

M. A., æt. 24, married, was admitted to the surgical clinic at Königsberg, Prussia, July 7, 1880. Until her marriage, five years ago, she was in perfect health. Soon after marriage irregular menstruations supervened. They would appear at intervals of eight to ten days, and continue for a like period. Three and a half years after marriage the menses disappeared for seven weeks, when, after appearing irregularly for a short time, they ceased entirely during the last four years. The patient has been conscious of an unpleasant sensation in her abdomen, but until lately has not suffered pain. Eighteen months ago she discovered an abdominal tumor, which has been gradually increasing in size. In last month pain has confined her to bed for a week at a time. She has never been pregnant. Patient is robust and well-nourished. Abdomen distended by a uniform swelling; greatest measurement 36½ inches. Palpation reveals firm, slightly un-

* Abstract of a paper read before the American Medical Association, April, 1885.

even tumor. Vaginal examination does not reveal the presence of a growth. The sound enters the cervix uteri readily, but can be pushed into the body only by depressing the handles of the instrument. An abdominal tumor was diagnosed. The operation was made July 28, 1880, under a spray of salicylic acid. The tumor sprang from the right ovary. A drainage-tube was inserted into the wound, which was closed by six quilled sutures, including the peritoneum, and twenty superficial sutures. Lister dressing.

Prof. Baumgarten described the tumor as follows: "Somewhat larger than an adult head, and is globular in shape. Its surface is smooth, and on one side the tube is attached. A section shows it to be an almost solid mass, from which, as from an opened honey-comb, there oozes, from innumerable orifices, a thick grayish-white secretion. Microscopic examination shows that the tumor consists of cysts, for the most part microscopic in size, the walls of which are covered with a single layer of epithelium, and are filled with mucoid masses."

Two months after leaving the hospital at Konigsberg she began to menstruate regularly. In 1881 she emigrated to America, and remained till the summer of 1884. In the spring of the previous year she discovered an abdominal swelling, which increased in size. Occasional severe abdominal pains, accompanied by vesical and rectal venousness, caused her to seek her bed.

Dr. Ranshof first saw the patient in October, 1884, in following condition: Rather robust woman, apparently in fair health. Abdomen presents evidences of first laparotomy, appearances of cicatricial tissue being present. Two inches above the pubes an ovoid body is felt. It measures an inch in width, and more in length, and is attached loosely to the cicatrix. The smooth surface of a tumor and the absence of adhesions is established. The tumor is central, and the abdomen presents a dome-like appearance; measuring, a little below the umbilicus, 42 inches. Palpation gives sensation of fluctuation. Vaginal examination shows the cervix high up and hard to reach. In the posterior cul-de-sac the vaginal wall is bulged downward by an elastic swelling, which is unconnected with the uterus, and by bi-manual examination is shown to be a part of the abdominal tumor.

In view of the history of the case and the signs presented, the diagnosis of multilocular ovarian cyst, with extensive pelvic adhesions, was made, and an operation advocated. This was done Nov. 19, with the assistance of Drs. Palmer, McKee,

Wilder, and Krouse. An incision four inches in length was made in the median line. On dividing the peritoneum, the typical grayish-colored multilocular cyst was found. Adhesions were not found. A pailful of thick, ropy, chocolate-colored material escaped from the cyst on tapping it. No pedicle could be found. The floor of the sac was so firmly adherent to the rectum, the body of the uterus, and left side of the abdominal wall above the latter, that a separation of these adhesions was wholly out of the range of possibility. In view of the extensive pelvic attachments, it was decided to sew a portion of the cyst in the abdominal wound. A glass drainage-tube was inserted, and the wound covered with boracic acid. An iodoform gauze dressing was applied. Time of operation, 50 minutes.

On the third day temperature rose to 104°, but fell again. Patient gradually improved for four weeks, when an abscess formed at the left of the wound. This was twice evacuated. The patient left the hospital in ten weeks after the operation. At this date, three months after the operation, the wound is completely healed, and the patient able to perform household duties. Since the operation the catamenial flow has occurred four times, each time lasting from three to five days.

The three points the essayist thought the case opened for discussion were: The comparative frequency of cystic disease in both ovaries, the advisability of performing double ovariectomy when the disease in one gland is but little developed, and the method of treating the cyst by suture to the abdominal wall after more or less of it has been excised.

While, in the experience of Sir Spencer Wells, both ovaries must be removed in 8 per cent. of cases, in that of others it is necessary in 16 per cent. Of 32 cases of second ovariectomies, only 5, or 15.6 per cent. ended fatally. In single ovariectomy Wells and Kœberle show a mortality of 22 per cent. In double ovariectomy Wells has lost 34 per cent. while of Kœberle's 51 per cent. have died. The author thought unless patient be near menarche period, or the disease in the second ovary be pronounced, double ovariectomy should not be performed. The author gave a tabulated statement of 32 cases where a second operation was performed.

The method of treating the cyst by sewing the small part, which could not be removed, into the abdominal wall, the author thought to be a feature of the greatest practical importance. For this procedure he ventured to suggest the name—*ventro-cystorrhaphy*.

CASES ILLUSTRATING THE USES OF THE GALVANO-CAUTERY.

BY WILLIAM F. WAUGH, M. D.,

Professor of Practice and Clinical Medicine, Medico-Chirurgical College of Philadelphia.

A lady consulted me for profuse leucorrhœa. Examination showed a small tumor springing from the inner anterior surface of the cervix. The slightest touch induced free hemorrhage, so that the view was obscured, and any operative procedure rendered difficult and uncertain. Having carefully introduced a Nelson's speculum, and waited for all hemorrhage to subside, I applied the cautery knife, at a dull-red heat, to the root of the tumor, and removed it with little difficulty. No hemorrhage occurred; the vessels being effectually sealed up by the heat.

Another lady had been long afflicted with nasal polypi. She had had them removed a number of times, but they had quickly reappeared. Ordinarily, we remove a few at each sitting, with forceps or wire snare: stopping when compelled to do so by the hemorrhage which obscures the view. In this case, after using the snare, I applied the cautery to the cut surface to check the bleeding, and was enabled to complete the operation at one sitting. I noticed then, that the patch of membrane from which the growths sprang, was studded with minute polypi, ready to develop at once, when the pressure of the larger tumors was removed. This surface was cauterized by passing the knife lightly over it; and there has been no return of the polypi.

A gentleman walked into my office some time ago, so woe-begone and emaciated that I did not recognize him until he mentioned his name, although he had been my patient for years. For two months he had been suffering with acute pain in his ear. During this period he had been under the care of an alleged specialist—a person who at intervals floods the city with advertising sheets, on which the anatomy of the ear is depicted by the aid of a few sorry wood-cuts. His treatment for the present case consisted in dusting a little iodoform upon the ear. Of its utility you may judge when I tell you that for weeks the man had been unable to masticate his food, or to sleep, and the pain was increasing daily. The external ear and the skin around it were swollen and reddened, as if with erysipelas. From the auditory meatus projected a raspberry-like mass, purplish in color, very sensitive, and bleeding when touched. I applied carbolic acid to its surface. (This was in pre-historic times, before cocaine was.) I then applied the cautery, using the utmost care to pre-

vent its touching the lining of the meatus, and burnt off the mass until I had penetrated about half an inch into the ear.

Here I noticed some smeary substance on the scoop used to remove the debris, and on examination found it to consist of thickened pus. The tumor proved to be a mass of granulations springing from the side of the meatus. When this had been removed, and the pus cleared out, I came upon a substance resembling wet paper, which was removed with a good deal of difficulty, as it was too rotten to remove with forceps, and too tenacious for the scoop. This consisted of epithelial scales mixed with aspergillus filaments. Finally the meatus was cleared out, and the drum could be seen. By this time the erysipelatous flush had disappeared from the face and ear, the pain had ceased, and the patient was relieved. He afterwards informed me that on the way home from my office he stopped twice to partake of stewed oysters, so quickly did his appetite return when the cause of his trouble was removed. The pain produced by the cautery was so slight that he did not mention it during the operation. Three days subsequently he returned with the whole meatus filled with a growth of aspergillus. This was removed, the cavity dried and painted with carbolized oil. The patient was instructed to dry the ear out with salicylated absorbent cotton whenever he noticed any moisture about it. There has been no return of the disease since.

These cases will suffice to illustrate the value of the galvano-cautery to the general practitioner. I do not mean to imply that the galvanically-heated knife is different in its properties from any other cautery, but practically it is vastly more convenient. In operating upon hypertrophied tonsils in children, we must not heat the knife until it is touching the tonsil, and the child need not know that heat is used; while few children would remain quiet if you approached them with a cautery iron just drawn from the furnace.

When one has become familiar with this instrument, he finds many other uses for it. Hypertrophy of the nasal mucosa, hemorrhoids with relaxed sphincter ani, warts, condylomata, pingueculæ, sluggish ulcers, and numberless other affections may be advantageously treated by it, even by physicians who have not the training of the specialists.

The apparatus I use was constructed by Otto Flemming, of this city, and leaves little to be desired in the way of durability, cheapness, and efficiency. It is so simple in management that a

child could operate it, and it does not get out of order. In the one quality of portability it is excelled by the Paquelin thermo-cautery.

PECULIAR CASE OF POPLITEAL ANEURISM.

BY C. D. CHALFANT, A. M., M. D.,
Of Streator, Ill.

It may be that the case which I wish to present to the profession has frequent parallels in the more extended experience of those engaged in an exclusively surgical practice, but I have been unable to find such reported in any literature of the subject which it has been my pleasure to read. It is on account of its apparent anomalous nature and the failure on my part to find any similar cases recorded that it would seem to present some points of interest, if not of frequent occurrence. But all surgeons who have operated for popliteal aneurism are aware of the many complications which may have to be met in its management, and the large mortality which the history of the operation has shown to occur in the hands of the ablest representatives of our profession.

Michael H., aged nineteen years, presented himself, April 24, for an operation, with following history: When seven years old was cut with mowing scythe, showing old cicatrix three and a half inches below head of the fibula, and he had been lame from that time with a pulsating tumor extending from that point up to angle of knee. Had been operated on for what was supposed to be talipes equinus, without relief, symptoms evidently due to pressure from aneurismal tumor. Had gradually grown worse for past eleven years. One year ago digital and instrumental compression had been thoroughly and persistently tried; with an apparently favorable effect for a short time; but after using limb, pain and lameness increased, and as a final resort, he determined to submit to any operative procedure for relief. The limb was losing sensibility, and ecchymosed spots were making their appearance on the foot.

Realizing that the chances of success were not very great, and that the mortality ratio was large, he was apprised of the facts, and I proceeded with the operation, ably assisted by a number of medical gentlemen of this city. Having ligated several times for traumatic aneurism, but never in the popliteal space, it was my pleasure to gather all the facts possible on the subject, and I had fully decided to tie in Hunter's canal or in Scarpa's triangle, but the condition of the tumor and obstructed circulation in limb, and desire to

save as much of leg as possible if it became necessary to amputate, caused me to cut down on the tumor, and tie both proximal and distal ends of the vessel. From the place of wound in the limb, the diagnosis seemed to point to the peroneal or posterior tibial as being wounded, and that tying one or both at point of injury might save the limb. After exposing the tumor and the firm bands of the soleus, and gastrocnemius muscles had been pressed aside, the sac gave way, and the coagula being turned out, the popliteal was tied. On investigation the posterior and anterior tibial and peroneal were found to be given off below, communicating with tumor. The fibula was nearly worn through, either by the constantly pulsating tumor for so many years, or the effect of the compression which had been so thoroughly tried the year previous, and its roughened edges had cut through the coats of the vessel until nothing seemed to hold it but the strong muscles external to it. With no reasonable hope of collateral circulation being sufficiently established, the leg was amputated by lateral flaps below the knee, but the subsidiary circulation from the muscular and cutaneous branches would not hold ligature, and Paquelin's cautery being of no avail, a secondary operation above the knee was made with about the same results, as every muscular fibre and arteriole seemed to bleed, the collateral circulation having been established by the development from childhood. At least twenty ligatures were applied, and as rapidly thrown off, actual cautery, warm and cold water, ice, astringents, all with indifferent success; but finally after three hours under the anæsthetic the hemorrhage ceased, and patient seemed to recover from the shock, and was comparatively comfortable until two hours later, when the circulation began to increase in volume and force. And although the stump was carefully watched for secondary hemorrhage, and tourniquet and Esmarch in place for emergencies, nevertheless the femoral broke, throwing off ligature and distal end of vessel with it, but was secured again at once, and tied; but patient gradually sank, and died from exhaustion three hours later.

Remarks.—The questions which this case brings me to consider are: Could anything have been done differently with better results? Had I tied in Hunter's canal or Scarpa's triangle, would results have been more satisfactory? So far as operation itself is concerned, every surgeon can appreciate with how much more ease this can be done than ligating in popliteal space. But the approaching gangrene of foot, and lost sensibility

of part from size of tumor, and obstructed return of venous circulation, seemed to direct the operation at the point selected; and yet were a similar case to present itself again, I should be in doubt whether to do the same operation or tie above the aneurism.

RECENT MEDICO-LEGAL MATTERS.

BY HENRY A. RILEY, ESQ.,
Of New York City.

A branch of law of great interest to physicians and surgeons, is that arising from the employment of the profession by servants of corporations in cases of accident, without the knowledge or authority of the higher officers. It cannot be said that there is any invariable rule on the subject, either fixing the liability for compensation, or relieving the corporation from it. Some of the States hold that the act of the employee binds the corporation in cases of emergency, and some deny that such is the rule.

The Supreme Court of Indiana has just decided a case in point by holding the corporation liable, and a statement of the facts upon which the judgment was rendered will be of interest:

Frankfort is a way station on the line of the Terre Haute and Logansport railroad, distant many miles from the principal offices of the company, and from the residences of the chief officers. At this station, at one o'clock in the morning of July 2, 1881, Thomas Coon, a brakeman in the service of the company, had his foot crushed between the wheel of a car of the train on which he was employed as a brakeman, and a rail of the track. The injury was such as demanded immediate surgical attention. The conductor of the train requested Dr. McMurray, a surgeon residing at Frankfort, to render the injured man professional aid, and informed the surgeon that the company would pay him for his services. At the time the accident happened, and at the time the surgeon was employed, there was no officer superior to the conductor at the town of Frankfort. There was at the station a resident agent, who had full knowledge of the injury to Coon and of Dr. McMurray's employment.

This agent was in telegraphic communication with the principal officers of the company, but did not communicate with them. Upon these circumstances, the court which tried the case held the railroad company liable, and a verdict of \$100 was rendered in his favor. The railroad company appealed from this decision, and the Supreme Court of Indiana has just decided that the judgment was right and must be affirmed. The court

considers at length the claim of the company that a conductor has no authority conferred upon him to employ surgeons and make the company pay for their services, when rendered without the knowledge of the officers, and that such action was totally outside the scope of his ordinary work as a conductor. After careful examination, it decides that in the special instance the claim does not apply. The rule that an agent can bind his principal only in cases within the ordinary scope of his employment is held to be a sound rule of law in most cases, but that an extreme emergency will give the conductor, who was the highest representative of the company at the place of the accident, the same powers to act that are ordinarily only enjoyed by the superior officials. Upon this point the judges say: "Can a man be permitted to die while waiting for the company to determine when and how it shall do what humanity and strict justice require? Must there not be some representative of the company present in cases of dire necessity to act for it? The position of counsel will meet ordinary cases, but it falls short of meeting cases where there is no time for deliberation, and where humanity and justice demand instant action. From whatever point of view we look at the subject, we shall find that the highest principles of justice demand that a subordinate agent may, in the company's behalf, call surgical aid when the emergencies of the occasion demand it, and when he is the sole agent of the company in whose power it is to summon assistance to the injured and suffering servant. Humanity and justice are for the most part inseparable, for all law is for the ultimate benefit of man."

HOSPITAL REPORTS.

LECTURES ON INSANITY.

Delivered at the University of Pennsylvania,

BY CHARLES K. MILLS, M. D.,
Lecturer on Mental Diseases in the University of Pennsylvania; Consulting Physician to the Insane Department of the Philadelphia Hospital; Neurologist to the Philadelphia Hospital; and Professor of Diseases of the Mind and Nervous System in the Philadelphia Polyclinic.

Reported by WILLIAM H. MORRISON, M. D.

LECTURE IV.

Melancholia—Definition—Varieties—Cases—Diagnosis from Mania—Diagnosis from Hypochondriacal Monomania—Prognosis—Treatment.

GENTLEMEN: Melancholia is the opposite of mania. It is a form of mental disease which has as its basis depression of the emotional nature. De-

pression may not be emotional, but rather logical, intellectual, or conceptional, and these very words indicate the differential diagnosis between two forms of insanity. Just as in mania, you may have with exaltation of the emotions other mental and nervous conditions, so in melancholia, depression of other functions as well as of the emotions may be present, but the depressed emotional state is the groundwork of the affection. Melancholia may exist in many degrees, just as is the case in mania. The simplest type is the one from which all present have probably suffered, and is termed a "spell of the blues," or "depression of spirits." Carry this to an extreme, and you have the idea expressed by the term simple melancholia.

Depression and dejection become profound. All the functions of the body become more or less stagnant. The speech, the countenance, the movements, the gait, and the general carriage of the patient, all express torpor and sadness. He breathes the air of despair.

"Black melancholy sits, and round her throws
A death-like silence, and a dread repose."

Melancholia has been sub-divided very differently by writers on psychiatry. One of the most recent subdivisions is that of Clouston, which is as follows: (1) Simple melancholia; (2) Hypochondriacal melancholia; (3) Delusional melancholia; (4) Excited (motor) melancholia; (5) Resistive (obstinate) melancholia; (6) Epileptiform (convulsive) melancholia; (7) Organic (coarse brain disease) melancholia; (8) Suicidal and homicidal melancholia.

After much consideration, I have concluded that it is better to subdivide into two chief forms, namely:

1. Melancholia without delusions, or simple melancholia.
2. Melancholia with delusions, or delusional melancholia.

It is possible to include all the forms of Clouston and others under one or the other of these heads.

Melancholia attonita, or stuporous melancholia, is a term sometimes applied to a condition in which the emotional system is absolutely overwhelmed; in which, indeed, to all appearances, not only the emotional, but largely the whole mental nature is overwhelmed, but at the bottom of the trouble is a terrible delusional condition. I prefer to consider this disorder under the head of *stuporous insanity*.

Melancholia, with delusions, takes many forms. In the first place, there is a distinct subdivision which can be properly termed hypochondriacal melancholia. Certain cases, often seen, cannot be well placed under any other head, and you have to speak of them as special forms of melancholia. In this condition of hypochondriasis or hypochondriacal melancholia, the patient's thoughts are centered on himself. He dwells on the condition of his organs and the diseases from which he thinks he is suffering. In one type of this hypochondriacal melancholia, he may have a distinct form of disease for almost every day—to-day, it is disease of the brain; to-morrow, of the liver; the next day, of the heart, and so on. You may sometimes, at a single interview, as I have done time and time again in my investi-

gations, lead such a patient to tell you of ten or fifteen diseases with which he believes himself to be suffering. He gives the symptoms of the various conditions as far as he can, but as a rule, he can give no logical reason for holding the views which he entertains about himself. In another type the patient holds with great firmness to his belief of disease of some one organ or part.

A common form of hypochondriacal melancholia is that in which the individual's morbid thoughts become centered on his sexual organs. Thoughts of impotence, of nervous break-down, of failing mind, etc., are demons which constantly pursue the victim of this delusional condition. Almost every physician of considerable practice has had to deal with many such cases.

Not infrequently I am consulted by mail by patients of this kind. The following is an extract from such a letter:

DR. MILLS—*Dear Sir:* The writer earnestly requests you, as a physician, to help him in a matter which is to him of great importance. When a boy, he was led, by an evil companion, into the degrading habit of self-abuse, which he ignorantly practiced for two and a half years—from the age of fifteen to seventeen and a half years—at which time, learning the evil of the thing, he ceased the practice. But the consequences remain, and now, at twenty-one years of age, he suffers from depression of spirits and physical weakness, produced by the practice. At times, the depression of spirits from remorse amounts to such unbearable anguish that suicide would be a sweet relief. He has practiced great abstemiousness in diet, and takes abundant exercise in open air daily, but has taken no medicine nor ever dared consult a physician and is unable at this time to pay any respectable physician. Won't you help him by giving him, however briefly, medical advice, and telling him what medicine to take? The present effects (physically) are nocturnal emissions, and the consequence, terrible depressions. Won't you, please, please, grant this kindness? Please tell him briefly by mail whether medicine will avail, and if so, what medicine.

Here you have a true sexual hypochondria, or sexual melancholia. I have been able to do most in these cases by carefully explaining the true nature of the case, and ordering change of scene, and medicines, such as hyoscyamine, hydrobromate, and atropia, for the relief of the emissions, if really frequent. Sometimes ocularia is present, and should be treated with mineral acids, diet, and laxative waters.

Delusional melancholia takes other forms. It may take the form of persecutory delusions, with hallucinations of voices or of sight. Sometimes it is the voice of some one in the neighborhood, calling and threatening; it assumes now one shape and now another; but the patient is able to give no logical reason for hearing the voices or for being the victims of persecution.

Sometimes even the diagnosis of melancholia from mania may be difficult.

The history of this patient, for instance, is as follows: She is 35 years of age and unmarried. Both parents are dead, the father having died of phthisis. One brother died in an insane asylum. She was always healthy as a child. Menstruation is regular. She has had syphilis. For the past eight or nine years she has had, but not frequently, general convulsions. These are probably attacks of epilepsy. In addition to these seizures she has had for the past year spells of despondency. When she has these attacks, she feels firmly convinced that she has committed some unpardonable sin, the nature of which she refuses to state; she thinks that she is going to die and go to hell. These spells last usually for several

days or a week. She had a severe spell in the ward a few days ago, in which she became excited, restless and agitated, walking about the ward, becoming almost maniacal in her manifestations, so that she had to be removed. The cause of this was the terrible condition of mental depression and despondency. Among epileptics you will find illustrations of almost all the forms of insanity according to any classification—mania, melancholia or monomania, and not infrequently, a cataleptoid or katatonic insanity. Here we have an illustration of lypomania or melancholia.

Sometimes, then, as in this case, a patient with melancholia will have attacks of excitement during the course of the melancholia. This patient became excited in consequence of the delusion which was depressing her. She became excited because she feared that she had committed some unpardonable sin, and that she was going to die and go to hell. This so preyed on her mind that she finally got into a condition of intense excitement. This was not mania, although it had the appearance of mania. If at the first visit the patient was found in this condition, the first duty would be to inquire as to the previous condition, in order that the case might be treated properly, for the treatment of such a condition is somewhat different from that of acute mania.

The general points in the differential diagnosis between mania and melancholia, as condensed by Seguin,* are these: In mania, the consciousness is exalted and overacting; in melancholia, it is the reverse, it is depressed. In the one case joy and excitement are the dominating features; in the other, sadness, fear, and religious feelings, often strongly pronounced. In mania, you have incoherent delirium and violent and extravagant actions continuing. In melancholia, you have usually reduced action, and at times absolute immobility. In melancholia often cataleptoid states are present. Insomnia is more common in mania.

A case of mania should not be treated as one of melancholia, and a case of melancholia with an attack of excitement occurring during the course of the melancholia, usually should not be treated as one of mania. Nine out of ten physicians called to a case of melancholia in a state of excitement would diagnosticate the case as one of mania.

Moral treatment will do something for these cases. This woman is improving, for she now thinks that there are probably other people as bad as she is. In treating acute mania, unconnected with any general condition, you would use, for an immediate effect, hyoscyamus, chloral or bromide of potassium in large doses; for a more permanent as well as its immediate effect, conium in large doses would be employed. Cases like the one before you sometimes do well on a sedative treatment, but frequently an opposite course is more beneficial. In chronic melancholia, small doses of opium will do a great deal. In cases with excitement, large doses are sometimes beneficial.

One form of hypochondriacal insanity, sometimes called hypochondria and sometimes hypochondriacal melancholia, is more properly, with our present methods of naming and classifying mental disorders, styled hypochondriacal mono-

mania. I have, for example, a patient, a young lady, who has had every tooth extracted, and since has had several painful operations performed on her gums. Her mind has been for years and is now centred upon the thought that she has some disease of her teeth and gums. Competent dentists and surgeons have pronounced her gums healthy, but without effect. Digestive, hepatic, uterine, and other trouble, real and imaginary, are attributed by her to disease of the gums. She reasons about the matter, and shows to her own satisfaction how this symptom and that must originate in her mouth. She is logically depressed, but not in general, emotionally depressed. At times, however, she gets into an almost despairing condition because she cannot get relief, and cannot convince others of her woes.

The following case is another instance of what might be termed hypochondriacal monomania, although the patient eventually committed suicide. J. G. W., aged 62 years, Scotchman, a widower, came to this country about thirty-five years ago. He had good health and steady employment in an office, where, besides acting as a clerk, he handled the goods, lifting them down from and up to the shelves. About 28 years ago he had syphilis. He never was a hard drinker, and for ten years had been a temperance man, having been connected with a temperance society for that length of time. The first time that he noticed anything wrong with him was several years ago, when he jammed his finger between two doors. He said that it did not bleed as it should, and would not heal, but that a material like cobwebs came out of the wound, and up his finger and hand, and from this time on he had been suffering from a discharge from the whole cutaneous surface, and more particularly of his head. The discharge, he believed, was like gum elastic, very adhesive, and when pulled off broke with a snap and curled around his hand, although he said it was invisible to a bystander. He complained of it gathering in knots in his body, and in the night oppressing his head so much that he had to remove the exudation, which was difficult, because it adhered so tightly that it dragged on his scalp. Treatment with the electric brush was tried, but had no permanent effect.

More than fifty per cent. of cases of melancholia recover. The prospect of recovery depends largely upon family history, careful feeding, and good physical conditions.

Incidentally, during the progress of the lecture, I have given a few points as to the treatment of melancholia; and, therefore, will only make brief general remarks. Melancholia, like mania, must be fed, not starved. Milk and eggs should be given in abundance, as should all forms of easily digestible food, particularly animal food. Lime water, pepsin, extract of pancreas, nitro-muriatic acid, and bitter tonics, should be given, as required, to arouse and assist digestion. Massage and general faradization will help the patient to assimilate more food, if it does nothing else. Fresh air, with moderate exercise, are important. Stimulants are generally useful, but should not be resorted to as a mere matter of routine. Malt liquors, good rum or whiskey, sherry and Burgundy may often be used with advantage.

* Hospital Gazette, August 22, 1878.

Opium is generally more useful than any other narcotic. Deodorized tincture of opium is a desirable preparation, and may often be given with advantage with tincture of digitalis. Granules of aloin are a form of cathartic highly to be recommended.

Bromides may sometimes be used alone, or in combination with opium and digitalis. As yet I have rarely used chloral or hyoscyne in melancholia.

Forcible feeding is often of great importance.

Quinine, iron, and strychnia are invaluable in the majority of cases as a continuing treatment.

Preparations of coca have been tried in a few cases with benefit.

Persistent, but not annoying, efforts should be made to amuse and divert melancholiacs.

MEDICAL SOCIETIES.

CINCINNATI ACADEMY OF MEDICINE.

Stated meeting, June 30, 1885.

President, Samuel Nickles, M. D., in the chair.

Dr. J. T. Whittaker reported two cases in which he used

Cocaine for the Opium Habit.

Both illustrated the incessant use of large quantities. In the first he practiced gradual, in the second sudden withdrawal. The first on his second return to the habit was treated with cocaine.

The second commenced with the fluid in the form of the tinct. opii, then took the solid form, then the morphia per os, then hypodermically, reaching as high as fifteen grains per day. When he first came under the doctor's care, on physical examination he found five hypodermic syringes. He was an old and successful merchant, who was weak-willed. His family were very sympathetic, and thus his surroundings were very bad. The doctor obtained a competent nurse, and withdrew the morphia at once. This was followed by collapse, mental depression, an attempt at suicide, and colliquative diarrhoea. Was obliged to return to the morphia for a time. Became able to walk about with a cane, but had pains and other uncomfortable symptoms. He went to Louisville to try the faith cure, and imported and supported the faith cure in this city. Later he returned to the doctor. His was a case of intense annoyance, preventing a comfortable night's rest on the part of his physician for a considerable period.

The second case was a lady. Withdrew gradually until reduced to $\frac{1}{2}$ grain. She then improved, and was free from the habit for three years. Unfortunately she was attacked with pneumonia. Morphia was used, and she returned to the habit. She returned to Cincinnati to be cured. Was taking two grains daily. Put her on hydrochlorate of cocaine in the fluid state hypodermically. Gave one-fourth to one-half of the usual dose. Immediate relief followed. There was a sense of comfort in the stomach, and exaltation for one-half hour, when the former ill feeling returned. The second time gave first a 5 per cent. solution, and then a 10 per cent. solution, giving 10 drops, which represented 1 grain of the latter. The patient immediately arose to a degree of exhilaration. In

one or two hours the sensation returned as badly as ever. He was obliged to give $\frac{1}{2}$ gr. morphia hypodermically. Gave the 10 per cent. solution of cocaine as before three times in the next 24 hours. In two hours at the outside would have the desire for morphia again. The patient has had no desire for morphia for two weeks now. The patient is loud in her praises of relief from cocaine.

This, perhaps, ought not to be cited as a case of cure from cocaine, but is certainly a case where much relief was obtained.

The doctor then went thoroughly into the literature of the morphia habit and cocaine. There is paid in India alone \$250,000,000 for license fees to sell opium. Richardson and Adams Allen say 100,000 people in the United States eat opium.

A wonderful tolerance in quantity can be established. There was once a preacher who took twenty-five grains of morphia every day. Cr  d   reported a patient who took fifty-two grains every day. The general range of those who indulge extensively is fifteen to sixteen grains per diem. He then described morphinism. The morphia eater goes about in a bent attitude, a peculiar gait, and cast of countenance; later is pale and yellow and changing. The eyes are a peculiar red. The eyes suddenly open with a dreamy look, stare awhile, and close again. Yawning is frequent. Tongue coated. The bowels alternate between constipation and diarrhoea. The patient lacks every capacity. The faculties generally degenerate.

Volley describes three distinct stages—inability, indifference, depression. Profuse sweating forms a prominent symptom. Strychnia, quinine, hyoscyamus, and cannabis indica all have had their trial. The physician is generally deceived by his patient; latter, will maintain that he is not taking morphia when he is. Volley says that it is incurable after five years. The fluid extract of the coca leaves was used five years ago. Cocaine varies from .2 to .02 per cent. in the leaves.

Moerck, of Darmstadt, has immortalized himself with his superior preparation. Coca is one of the oldest remedies in history. Eight million people are in daily use of the coca leaves. The oldest travelers in Peru mention improvement in the respiration, muscles, ideas, and spirits, on the use of coca leaves. The Indians in Peru work at very high altitudes and perform immense labor in the silver mines under the influence of the coca leaves, which they chew as tobacco is here. The priests forbade its use at first, but relented when they found out how much more gold and silver the Indians could bring out of the mines under its use. The leaves were first used in 1758. In 1859 the alkaloid was separated by Niemann. In 1880, its injection hypodermically produced a local area of anesthesia. 1884 was the era of Koller and Moerck. This year it was first used for the morphia habit, January 3, by Volley. He found it to cause a suffused warmth over the body; the patient lost his depression and exhilaration was produced.

The doctor said he had fashionable ladies come to him to get hypodermic injections of cocaine to make them lively and talkative. He hoped it was needless to tell the Academy that he had always refused. After an injection of cocaine, the pupils dilate in from seven to ten minutes; also widen-

ing of the lids occurs. The union of cocaine and morphia is said to relieve pain entirely.

The reporter thinks cocaine the best remedy for the morphia habit that we have. Straus says he has recovered morphia locked up in the tissues of the body thirteen months after death. This may well explain why relapses occur. The reporter gave his experience with opium smoking in an Arabian coffee house.

Dr. W. H. Wenning reported a case of the morphia habit.

Dr. J. C. Cleveland said his experience had been negative. He thought control of the patient all important. Tea and coffee are good remedies unless the patient is habituated to their use. His results with atropia have been negative.

Dr. C. O. Wright gave his experience in an opium joint. The smoking with him was followed by very unpleasant after-effects.

Dr. M. Cassat related his experience in an opium joint in San Francisco.

Dr. S. Nickles, the president, said: The physiological effects of cocaine are a peculiar physical excitement. This peculiar happiness and joy lasts for a few hours. If the amount taken reaches excess, paralysis intervenes and the patient dies. It is probable that the dose would have to be repeated frequently, and then the cocaine may become just as bad as the morphia. He thought that cocaine acts in no way as an antidote to opium. He thinks it acts only by its action on the cerebrum. He thinks toxic doses of morphia can be taken for years with no disastrous effect. Cocaine will prove an admirable remedy to counteract the depression; nothing but the will of the patient will cure the morphia habit. Did not think morphia remained long in the tissues locked up.

Dr. Philip Zenner thought cocaine a good remedy to ward off the collapse, in the same way small doses of morphia are used. He doubts if it ever acted otherwise.

Dr. Robert Stewart asked if cocaine could be used in case of morphia idiosyncrasy.

Dr. Nickles thought not.

Dr. Whittaker in closing said, morphia remains in the tissues often for a great length of time. Thus we sometimes get the effect of a dose weeks maybe after it is administered, and in the same way we may have a return to the morphia habit after a period of abstinence, from the liberation of this locked-up morphia. Recommended warm baths, friction, massage, and alcohol. Spoke of the effect of opium on the appetite. Cocaine gives relief only for the time being.

Stated meeting, June 1, 1885.

Dr. A. G. Denny reported a case of

Double Ovariectomy.

Mrs. R., et. 30, mulatto, mother of four children, noticed for a number of years pain in the left inguinal region, and for two years a tumor in the same locality. The doctor found later that tapping would be necessary. After this was performed, he noticed in the left ovarian region a tumor the size of an egg, and freely movable. It was necessary to repeat theappings until they numbered twenty-three, and an aggregate of eighty gallons had been withdrawn. The intervals had gradually shortened, until only eight days occurred between theappings. When the

tumor reached the size of an orange the doctor advised an operation, which was concurred in by Drs. J. L. Cleveland, Geo. E. Jones, and W. H. Wenning. This was refused. Two months later a fatal termination seemed imminent. Dr. P. S. Connor saw her, and advised an operation, which was done. The peritoneum was found largely adherent to the wall. The left ovary consisted of a mass of cysts, varying in size from an egg to a pea, and filled with fluid, attached in many places to the surrounding viscera. These attachments were broken in most instances without any very great difficulty. The right ovary was only one cyst, filled with a caseous substance nearly ready to suppurate. Both pedicles were normal. General peritonitis followed the operation, and death occurred in thirty hours. Only a hurried and imperfect post-mortem was obtained.

Dr. Fred. Kehler examined the specimen, and reported that in his opinion the growths were cystic adenoma of the ovaries.

Dr. Cleveland and Dr. Wenning discussed the case, giving many more points in the history.

Drs. T. A. Reamy, J. T. Whittaker, C. D. Palmer and Joseph Ransohoff, discussed the cases, all maintaining that it was not the ovaries which were at fault, but that the case was one of tubercular peritonitis.

Dr. Philip Zenner reported two cases of Lead Poisoning.

The one was interesting because it showed the primary stage of this trouble, a stage in which the physician rarely obtains charge. The paralysis merely involved the muscular slip to the tendon of the ring-finger, and the extensor communis digitorum of the right hand. There was no drop-wrist, but the hand was readily pushed down, and there was a tremor present. In the second case there was paresis of the deltoid, causing an inability to lift the arm. Both cases showed the usual symptoms of lead poisoning.

Stated meeting June 15, 1885.

President Samuel Nickles, M. D., in the chair.

Dr. Thad. A. Reamy reported a rare case of

Cyst of the Posterior Vaginal Wall.

The patient was a blonde woman, married, of excellent general health, weighing 150 pounds. Her father had been an exceedingly nervous man. Otherwise there was nothing special in her family or early personal history. At the age of 23, after she had borne one child, she became aware of a tumor lying posterior to the vagina. She consulted several doctors, and was preparing to go east to consult further on the advice of the gentlemen who had seen her, when she found herself again pregnant. This pregnancy ran the usual course without noteworthy occurrence, except that the patient vomited once or twice each day during the whole nine months. This was also the case in the former pregnancy.

She came to Dr. Reamy after the tumor had existed for four years. He found it to be quite large. With the patient in the erect posture, it extended down to the posterior commissure of the vulva. In the dorsal decubitus it retreated two-thirds of the distance up the vagina. The doctor made an exploratory puncture, and was induced to evacuate the tumor at the same sitting. He then explored the sac with the probe, finding it to

be quite extensive, but having no outlet so far as he could discover. The cyst refilled. He again aspirated, and this time curetted the cyst. The patient showed some unpleasant symptoms after the first evacuation. This time she was taken with obstinate pain and uncontrollable vomiting, severe posterior cephalalgia, and partial opisthotonos. It being quite impossible to retain anything on the stomach, she was nourished per rectum for eight days. The symptoms gradually subsided, and the patient is now convalescent. The cyst has not entirely disappeared, and still gives off a slight discharge. Examination of the fluid withdrawn showed the absence of albumen, but the presence of small quantities of the chlorides. The doctor considered the possibility of the tumor being anterior spina bifida, a hemocele, rectocele, vaginal cyst, subperitoneal cyst, and cyst of the broad ligament. Though still quite undecided as to diagnosis, yet he was of the opinion that it was the latter. He then reviewed the scanty literature on the subject, mentioning the two cases reported by Thomas in the March number of *Gaillard's Medical Monthly*, 1885, and a case of Emmet's, reported in the last edition of his system of gynecology.

Dr. C. D. Palmer spoke of the extreme rarity of cysts of this nature; all opinions he thought must be more or less speculative, unless it was that of the gentlemen who had had the opportunity of close observation. He was inclined to think that the trouble in question was anterior spina bifida.

Dr. E. G. Zinke reviewed the German literature on the subject, which he found not nearly so meagre as the English. He thought the case reported must be one of a cyst of Gärtner's ducts.

Dr. P. S. Connor thought the doctor anticipated too much trouble. He should wait till patient had improved, and cauterize the cyst well.

Dr. J. T. Whittaker was of the opinion that some of the severe symptoms were hysterical.

TRANSACTIONS OF THE CHICAGO GYNECOLOGICAL SOCIETY.

Friday evening, 29th May, 1885. Regular meeting.

The society was called to order by the President, Dr. H. P. Merriman.

An inaugural thesis, entitled,

The Normal Position of the Uterus, and its Relation to the other Pelvic Organs,

was presented by Franklin H. Martin, M. D. (Chicago Medical College, 1880), and read by the Secretary, Dr. Edward Warren Sawyer.

The extreme theories of Schultze, Fritsch, and Savage were opposed for the following reasons:

1. In extreme anteversion, the wave impulse would strike the posterior broad surface of the body of the uterus, and drive it down upon the bladder and anterior wall of the vagina, while, on the other hand (the perpendicular theory of Savage), the anterior broad surface of the body would receive the impulse to an equal disadvantage, displacing the uterus backward and driving the cervix downward, while if the uterus occupied the position between these two extremes, the narrow crest of the fundus would receive the impulse in the line of the axis of the

uterus, and all the force would become equally distributed through all of its supports. Here, too, the organ would not so directly receive the whole impulse, as it would be equally dispersed upon its sides and the posterior ligaments and anterior supports, and its lateral attachments would receive, to an equal extent, their portion of the impulse.

2. The manner in which the bladder collapses, to our mind, precludes the possibility, or at least the probability of the uterus occupying normally the position of extreme anteversion. The bladder, when collapsed, or when empty, is a triangular-shaped body—not flat like a plate—the base corresponding to its peritoneal surface, the apex corresponding to the urethra. The posterior or inferior surface corresponds to the anterior wall of the vagina, to which it is intimately attached; the anterior wall corresponds to the symphysis, to which it is loosely attached. It is readily seen, then, that the bladder distends only in the direction of the peritoneum, or its one free surface. According to the extreme anteversion theorists, the free surface of the bladder and the uterus are in apposition. If such be the case, the uterus changes its position constantly, as the bladder normally relaxes or contracts—this seems to us very improbable. We believe that this space is usually filled with the light coils of the small intestines.

3. The broad ligaments receive their external attachments at a point about equidistant from the centre of the sacrum posteriorly, and the pubic junction anteriorly, in such a way as to divide the plane of the brim of the true pelvis into about equal halves. If the body of the uterus occupies a position in the centre of the pelvis on a direct line with the ordinary attachments of these ligaments, which it is at least rational to believe is the case, it occupies a position between the perpendicular of Savage, and the extreme anteversion of Fritsch.

4. With extreme anteversion, the cervix, with the fundus occupying a position behind the symphysis, would necessarily have to occupy a position far back in the pelvis, within three-fourths of one inch of the sacrum—with a normal conformation of parts, this is impossible without interfering with the rectum.

5. If we take the measurements of Foster and Litzmann into consideration, we can at once demonstrate the impracticability of the position given by Savage—i. e., the perpendicular. The cervix occupies a position, normally, at a distance of one and one-half inches from the sacrum, the rectum intervening. It is impossible for the uterus to assume anything like a perpendicular with the cervix in this position, on account of the anterior curve of the sacrum above, which necessitates an anterior version from the perpendicular of at least fifteen degrees.

DISCUSSION.

Professor W. W. Jaggard was pleased with the selection of the topic, and its mode of treatment, but did not agree with Dr. Martin in all his conclusions.

Bandl had made a correct statement of the diversity of opinion upon this subject, in his essay on "*The Normal Position and the Normal Re-*

lationship of the Uterus, and the Pathologico-Anatomical Causes of the Symptom of Antelexion," (*Archiv. für Gynäkologie*, Band. xxvi., Heft 3, 1884,) read before the Gynecological Section of the *Versammlung deutscher Naturforscher und Ärzte* in Freiburg, September, 1883.

"In the course of time, almost every position of the uterus, with the exception of prolapse, has been accepted as the normal by different anatomists and gynecologists, and particularly by the more eminent ones."

Köllker (1882), from a series of examinations of the cadavers of girls, from ten to eighteen years old, has concluded that the uterus is not bent, nor curved upon itself, but is straight, and that its long axis corresponds with the principal axis of the small pelvis. Its position is variable within certain limits, depending upon the condition of the bladder and rectum. This opinion coincides closely with judgments of Kohlrausch (1854), Le Gendre (1868), Freund, Carl Braun (1857), J. Marion Sims (1855), Langer (1881). Professor Paul F. Munde, in his recent excellent work on "Minor Surgical Gynecology," favors these views to the extent that he says, "with the woman in the recumbent position, the examining finger is unable to touch the body of the uterus before or behind the cervix, if the uterus is normally situated."

Bandl, in the paper to which allusion was made, confirms Köllker's view. The evidence he furnishes is of a high order. His methods of investigation were:

1. The attentive examination of living women.
2. Examination and observation before and during the operation of laparotomy.
3. The bi-manual examination of the organ in cadavers, before and after abdominal section.
4. The comparative anatomical examination of many uteri.

Dr. Philip Adolphus thought, with Emmet, that "there is no common standard by which to determine the proper position for the uterus in all women, but that in each individual there is a point, or plane, in the pelvis which the uterus should occupy when she is in a state of health and not pregnant." He referred in detail to Emmet's "normal or health line," and to the pathological character of displacements above or below this line. It was a matter of relative insignificance whether or no the long axis of the uterus coincided with any particular pelvic axis.

In the concrete case, the sensations of the individual would indicate a normal or abnormal position.

Professor Daniel T. Nelson said the uterus was fixed in a position of unstable equilibrium by the annular and other ligaments. It could move to a certain degree in every direction, and return to its original, normal position. Displacement above or below Emmet's "health line" was productive of symptoms, if the uterus remained fixed in such a position, as was usually the case when violence caused the dislocation. Departure from the principal axis of the pelvis was of comparatively insignificant moment, viewed absolutely. The vagina and perineum are not primary supports of the uterus, and only assume this function when, as the result of the relaxation of the proper uterine supports, the organ is displaced downwards. This secondary character of the vaginal and

perineal support was capable of demonstration by the examination of a woman in the erect attitude. Upon coughing or sneezing, the uterus would descend and receive support from vagina and perineum, only to regain its original position when the excitant was removed. This remark applied exclusively to normal organs in normal position.

He wished to emphasize the statement that the rectum was not the normal receptacle for the feces. Anatomy and physiology teach that in the normal condition the gut is empty up to the sigmoid flexure. The sigmoid flexure is a sort of valve to retain feces.

He narrated the history of a case of retention of urine in a puerperal woman, in which the bladder was displaced towards the left iliac fossa, while the uterus was directed towards the right. He would like to ask the Fellows if this displacement, observed in a single case, corresponded with their observations.

Professor Charles Warrington Earle related the history of a case of retention of urine in a puerperal woman, the bladder displacing the uterus upwards and backwards. Upon the introduction of a catheter, four quarts of urine were evacuated, and the pelvic viscera returned to their normal relations.

Dr. Edward Warren Sawyer said the uterus had great latitude of movement antero-posteriorly and laterally; elevation above or depression below the normal plane, even to a slight degree, was productive of pain. The introduction of a pessary, which merely elevated the uterus when partially prolapsed, without altering flexion, was sufficient in many cases to afford complete relief.

While a student in the Medical Department of Harvard University, he had taken plaster casts of the vagina. Such casts were of uniform shape, while they differed in size. They were curved, convex posteriorly, concave anteriorly. They were never shaped like an S. The curve did not correspond to that of the anterior surface of the sacrum, but to the floor of the pelvis.

Dr. H. T. Byford thought Dr. Sawyer's experiments were faulty. When plaster of Paris was injected into the vagina, with the rectum empty, the vagina would act exactly as the rectum would under similar conditions.

The President, Dr. H. P. Merriman, complimented the author of the paper on the careful, judicial mode of treatment of his difficult subject.

He agreed with Dr. Adolphus, Dr. Nelson, Dr. Sawyer, that elevation above or depression below a certain horizontal plane was of greater importance, in the production of symptoms, than deviation from the principal pelvic axis antero-posteriorly or laterally.

The normal position of the uterus was as variable as the quantity of blood lost at a menstruation. Every woman was a law unto herself. He referred in detail to Robert Barnes's theory of uterine support, and concluded by recommending Bozemann's plan of columning the vagina, when a hard-rubber pessary could not be borne.

Professor Christian Fenger, M. D. (Copenhagen, 1867), and Franklin H. Martin, M. D. (Chicago Medical College, 1880), were then elected Fellows of the Society.

W. W. JAGGARD, M. D., Reporter.

2330 Indiana Ave., May 29, 1885.

EDITORIAL DEPARTMENT.

PERISCOPE.

A Case of Syphilis, in which Ataxy and other Nervous Disorders Occurred at an Unusually Early Period.

Dr. T. Churton thus writes in the *Brit. Med. Jour.*, June 27:

John P., aged 24, of medium size, light hair and complexion, normal weight 11 stone 6 lbs., but now reduced to 10 stone, a groom, able when in health to ride any horse, to walk thirty miles a day, and to endure long abstinence from food, accustomed to drink rather heavily both of beer and spirits, was admitted into the Leeds Infirmary on December 19, 1884. He was quite unable to walk; he could stand, even when supported on both sides, with great difficulty, anxiously looking down all the while at his legs, and so tending to fall forwards, being unable to balance his trunk upon his lower limbs. He had also lost power of coördinate movements in his upper limbs; could not cut up his food; could not even pick up a match without great trouble and bungling; he could not, moreover, tell by mere sense of touch what the match was. His grasp was, however, not very feeble; he complained of numbness and "pins and needles" in his fingers, especially in those of the left hand. He had similar abnormal sensations in his feet, especially in the left. His replies to questions were hazy, and, when repeated, variable; he seemed rather dazed. There was no tenderness nor swelling of bones and joints; no special wasting of muscles. The plantar and patellar reflexes were absent; the cremasteric and abdominal present; the pupils, optic discs, and retinae were normal. Hearing, etc., was not notably altered. The urine, on being heated, gave a marked phosphatic cloud. The organs of supply, circulation, and elimination were not particularly affected; he stated, however, that he had suffered a few weeks previously from epigastric and abdominal pains, with some giddiness. In the right groin was a dusky red scaly rash; on the inner side of the right thigh was a similar, but much larger patch; on the penis, a cicatrix was found.

At first denying syphilis, he subsequently gave the following history. At seven years of age he had rheumatic fever, but no other illness until two years ago, when he had gonorrhoea; sixteen weeks ago he had a chancre, followed by an enlarged gland in his left groin; three weeks later, he had a sore throat and a rash on the neck; he was then treated for syphilis, but not continuously. His parents are alive, but ailing; in his family there is neither nervous disease nor phthisis. Five or six weeks ago his right toes began to be numb and tingling; he staggered when he walked; the numbness spread up the leg; then the left foot and leg became affected; he was obliged to look at his legs when walking; he could not stand with his eyes shut or in the dark. At this time he was still drinking rather freely. A fortnight ago (December 5) he was quite unable

to walk. Ten days ago his hands became numb and weak.

Upon this history being gained from him, mercurial inunction was at once begun; one drachm of blue ointment being rubbed in daily. He was kept at rest, had good food, and no alcohol. He improved rapidly, so that on January 10 he could walk fairly well, could stand for a few moments with closed eyes, could cut up his food, grasp the dynamometer (right 53, left 51), distinguish two points of the aesthesiometer on the finger-tips at a quarter of an inch from each other, and at one inch distance on the instep. The plantar and patellar reflexes were still absent. The inunction was continued until January 17. He was discharged almost well on the 21st. A month later, the reflexes were normal.

Though the leading and most prominent clinical features of this case were finally seen to be those of locomotor ataxy, or posterior sclerosis, it cannot be taken as a simple case of that disease. The patient could neither walk nor stand at all, eyes shut or eyes open; so that, though he looked constantly at his legs when supported in the erect position, the sight of them did not help him. The equilibrating organ could not avail itself of information, reaching it through any channel. The really noteworthy feature of the case, however, is beside its accurate pathology. For the patient, having been quite well four months previously to admission, and having then contracted syphilis, presented distinct symptoms of serious nervous disorder two months afterwards. I have previously seen nothing so rapid as this, except upon a single occasion.

Some years ago a similar case came under my observation. A young man, within a few months of his having contracted syphilis, presented, in addition to complete ataxy, certain specific signs which John P. did not present—for example, paralysis of the third nerve on one side. In him, perfect recovery ensued upon the very vigorous use of mercurial treatment, moderate treatment having been found wholly ineffective. Some authorities state that nervous diseases due to syphilis are not to be expected until from three to eighteen years have elapsed since the syphilis was acquired; but neither are changes in the arteries expected until after an equal lapse of time, yet cases have been recently recorded by Dr. Sharkey and M. Leudet, in which arteritis has followed the original sore in a few months. Now this question of the lapse of time appears to be one of some importance, for I do not remember ever to have seen a case of ataxy occurring many years after even indisputable syphilis, in which strong anti-syphilitic treatment has done any good whatever; early cases, on the other hand, seem to require very decided treatment. The reason why later cases are unaffected by that treatment has appeared to me to be that, during the interval, other causes of disease, perhaps several, or even many, have come into operation, and, aided to some extent by the specific taint, have brought

about a condition of the nerves and sheaths which the syphilis alone had shown itself, even when in full vigor, unable in these persons to achieve. In such circumstances, no simple treatment, no single drug, no one precaution, is sufficient, or scientific, or in accord with common sense. It has been shown, indeed, that even such compositely caused disorders are not, when treated early, at all hopeless. But the case now under consideration is one of syphilis affecting, at an unusually early period, motion slightly, and coördination of sensations and movements gravely. Such cases appear to be as easily curable by vigorous treatment, specific and otherwise, as the commoner form of localized paralysis, due to a simple gummata.

Diabetic Neuralgia.

Cornillon (*Revue de Méd.*, Paris, March, 1884), after passing in review the writings of Dreyfous, Worms, Drasche, and others on the subject, relates two new cases of his own, in which cervico-brachial neuralgia, first on the left and then on the right side, and symmetrical sciatica, were evidently owing to the saccharine condition of the blood. Such cases are, on the whole, rare, as until now only twenty-two are on record. On analyzing these, it is found that glycaemic neuralgia is not generally an initial symptom of diabetes, but occurs rather when this condition is confirmed, and when there are much loss of power, emaciation, and polydipsia. It comes on quite suddenly; the patient goes to bed apparently as well as usual, and is suddenly awakened up by a fearful attack of pain which drives him out of bed; or the pain comes on on waking in the morning, after a somewhat restless night. It is continuous, terebrating, or lancinating, or lightning-like, and there are occasional paroxysms which exceed in keenness and duration the most violent exacerbations of other forms of neuralgia. These attacks occur three or four times a day, after meals, and again on going to bed. The pain is so violent that one of Worms's patients threatened to commit suicide; one of Drasche's ran about in his room yelling and screaming. The nocturnal attacks appear to be worse than those which occur in the daytime. One of Cornillon's patients did not go to bed for several months, from fear of the heat of the bed bringing on a bad attack. The pain is sometimes localized in the course of certain nerves; at other times it will also affect the muscles and bones. Digital pressure on the course of the nerve increases it, while compression all the way round rather relieves it. There is generally no fever, the skin is cool, the pulse normal; Buzzard, however, has seen a slight elevation of temperature, which is quite exceptional. If the pain continue for any length of time, there are loss of sleep and appetite, and great depression of spirits; but on the disappearance of the pain the patients recover themselves rapidly.

One of the most striking features of diabetic neuralgia is its symmetry. This was seen in eighteen cases out of twenty-two. It is, however, rarely at once symmetrical; more frequently one limb is first affected, and its fellow only follows suit a few days afterwards. The same nerve-fibres are then affected, the distribution being quite regular. The pain, however, is generally

worse in one limb than in the other; and mostly so in the one that was first affected. In Drasche's case it was bi-hemiplegic, in this way, that it was first perceived in the right leg, then proceeded to the arm, forearm, and fingers of the same side; after a time the lower and then the upper limb of the opposite side was affected; and in one of Cornillon's cases it alternated so that at first the left cervico-brachial plexus suffered, and some months afterwards the same plexus on the other side. The quantity of sugar in the urine was in most cases large when the neuralgia appeared; in a few, however, only minimal. In general an anti-diabetic treatment, by alkalies and diet, rapidly relieved the suffering, and the improvement went *pari passu* with the diminution of sugar. The attacks occurred then more rarely, and were less severe; but if the patient broke the regimen, the pain would return in its old intensity.

The prognosis is, therefore, rather favorable, if the true nature of the disease be recognized; but if it be not properly understood, the muscles will gradually waste away, and anesthesia of the skin sets in, which proves intractable.

The diagnosis does not present any great difficulties. It should, however, be recollected that not every neuralgia which occurs in the course of diabetes is of glycaemic origin. Where it is independent of the glycosuria, it may be owing to carious teeth, when it affects the dental nerves; or to cold, fatigue, etc., and then selects those parts which have been principally exposed. Such neuralgia is generally unilateral, the attacks being of medium or even slight intensity; and the pain generally yields in a few days to ordinary treatment. On the contrary, where glycosuria is the cause, the neuralgia appears suddenly and without any appreciable exciting cause; there are three or four long attacks during the day, and the pain is intolerable; it is mostly symmetrical, and invades more particularly the sciatic plexus. It resists the ordinary treatment by morphia and salicylate of soda, and yields to anti-diabetic treatment only. Saturnine neuralgia is also symmetrical; but it has a different history, and the urine does not contain any sugar.

Rosenstein considers the diabetic neuralgia, as well as the glycosuria, to be owing to venous congestion in the abdominal organs; but this theory is unacceptable, as then sciatica would be much more common than it really is, and it would also habitually occur in persons suffering from piles, chronic nephritis, tumor of the spleen, congestion of the liver, etc.; such, however, is not by any means the case. Moreover, diabetic neuralgia occasionally affects the brachial plexus, the intercostal nerves, and the fifth pair. Worms, on the other hand, considers the excessively saccharine state of the blood to be the cause, whereby he thinks that an anatomical or dynamic modification of the nerves is produced, just as in gout and lead poisoning. This explanation is accepted by Drasche and Peter; but it is refuted by the circumstance that in some cases there is only a minimal amount of sugar in the urine, and the preceding symptoms of diabetes, such as polydipsia, emaciation, loss of power, etc., have only been slight. Cornillon is of opinion that diabetic neuralgia is owing rather to the presence of uric acid

in the blood, since most patients have had gouty or rheumatic antecedents, and sciatica is a somewhat common symptom of gout. As for any pathological lesion in the nervous system, it is evident that we have not to do with neuritis; for there is no pyrexia, no vesicular or pemphigoid eruption, no paralysis: on the other hand, the fact that this form of neuralgia is very obstinate, and affects homologous nerves, tends to show that there must be a temporary, although not extensive lesion of the spinal cord. In what part of the spinal centre it may be situated, whether in the membranes near the posterior columns, or in the white or gray matter of the cord itself, it would be premature to say, as no necropsy has as yet been made.

Perforating Ulcer of the Bladder.

Dr. James Oliver thus writes in the *London Med. Times*, July 18th:

The type of ulcer I am about to describe as affecting the bladder, has hitherto been looked upon as more or less peculiar to the stomach and duodenum. When, however, we consider the probable cause of its formation, it is not to be wondered at that other parts of the intestinal canal, and even the bladder itself, may become the seat of a similar necrotic change. In the *Lancet* of March 7th of this year, I recorded a case in which the ascending colon had been thus perforated, and doubtless careful pathological observation will prove that such are not uncommon.

Perforating ulcer of the bladder is primarily always acute; if, however, there be extensive destruction of tissue, the functions of the organ are likely to be permanently disturbed, and the disease to become one truly chronic in character. This ulcer is especially apt to recur, a fact strongly in favor of a diathetic tendency or proneness to the affection. It usually develops without signs of inflammation or suppuration, and as in the stomach and other parts of the intestinal tract, apparently results from a plugging of the vessels which run in and nourish the coats of the viscous. If the blood supply to any tissue of the body be suddenly withdrawn—as happens when a vessel becomes occluded—and collateral circulation be not readily established, death of the part is inevitable. Embolism and thrombosis are the most frequent causes of softening in the brain and spinal cord, and it is more than likely that these play an important part in the production of perforating ulcer of the bladder. Round ulcers, similar to those we are now considering, have been produced in the stomachs of animals artificially by the introduction of emboli into the gastric vessels. This form of necrosis is truly analogous with dry gangrene occasionally seen in the extremities of the aged, where the arteries, because of the degenerative changes in their coats, have become impervious. The embolic theory of chorea is still tenable, and all who see much of this disease remark its frequent association with rheumatism or a rheumatic predisposition. Judging from those cases of perforating ulcer of the bladder which have come under my notice, I am inclined to believe that the rheumatic diathesis augments the tendency to this affection, and favors embolism as a probable cause of its produc-

tion. In one case the symptoms attributable to perforating ulcer developed during an attack of acute rheumatism, and as the patient died some time after, opportunity was afforded for examining the bladder and verifying the diagnosis. The heart in this case showed no trace of valvular disease. Females, it would appear, are more prone to this affection than males, and especially about the period of puberty. No exciting cause can as yet be suggested.

One or more ulcers may develop, according to the number of vessels occluded; some days, however, must necessarily elapse before disintegration is completed. Whether the necrotic change shall invade the whole thickness of the bladder wall or not, depends on the seat of obstruction of the artery, the completeness or incompleteness of the plugging, and the period at which collateral circulation becomes established. Should, however, the destructive process attack all the coats of the bladder, and at a part covered by peritoneum, this coat tends to thicken and form adhesions with neighboring structures, it may be the small intestine or omentum, thereby preventing rupture of the organ, extravasation of its contents, and death by shock or peritonitis. If the bladder forms adhesions with any part of the intestinal canal, the ulcerative process may extend and invade this organ too; vesico intestinal fistula, though fortunately rare, may therefore depend upon simple perforation. In such cases even a careful inquiry into the clinical history may fail to reveal the probable starting-point.

The symptoms and course of perforating ulcer of the bladder are usually very insidious, and fatal peritonitis may result from destruction of all the coats ere the grave condition has been recognized. Pain more or less constant and referred to the hypogastrium is a frequent symptom—it is aggravated by pressure and any slight distension of the organ. There is frequency in micturition, and the pain, as a rule, becomes sharp and cutting in character towards the end of the act. The most distressing symptom of all is tenesmus, which results from spasm of the muscular coat, and may continue for some time after the organ has completely emptied itself. Blood usually appears in the urine about the third or fourth day, is small in quantity, and is expelled with the last drops of urine. The treatment is rest and bland food; opiates must be given to relieve pain and the intense bearing down.

Control of the Lactal Secretion.

Dr. J. Stuart Nairne thus writes in the *British Medical Journal*, June 27, 1885:

The breasts of parturient women frequently give trouble from engorgement of the lactiferous vessels, and from other causes leading to tension and pain in these organs. The two following cases will illustrate the line of treatment I have followed for some years past under these circumstances, and which has never yet failed to afford me perfect satisfaction, and my patients perfect ease.

Case 1. Mrs. G., multipara, was confined of a dropsical and malformed dead child, at full time, on March 14, 1885. The breasts, which had been small and hard before confinement, soon became

engorged and swollen; and the patient was hot and feverish. Cloths moistened with whisky and vinegar were laid on the breasts, and ten drops of the tincture of belladonna were given every hour. Within twenty-four hours, the throbbing, which had been very troublesome, had ceased; milk could be easily expressed from the nipples, and she complained of a very dry throat. When the throat began to become dry, the number of drops of the tincture was diminished. During ten days she had this treatment; the last few days, ten drops only three times a day; and by that time the milk had almost entirely disappeared, and the breasts were small and flaccid. They gave no further trouble.

Case 2. Mrs. C. was confined of her second child on May 25, 1885; it was very weakly, being born before its time. She had a rapid rush of milk to the breasts; and next day these organs were very much enlarged, tender, and hard, and the child could draw no milk from them, and was so weakly that I thought it would die. It was, therefore, fed with a spoon, and the tincture of belladonna was given internally, as in the first case. The breasts were supported, and gently rubbed from the circumference towards the nipple. Next day, she said she felt hardly any pain, and the milk could be easily expressed from the nipples. The belladonna was continued another day, by which time the breasts were so soft, and the milk was flowing so freely, that the child was quite able to take its own nourishment. The belladonna was then stopped, and the breasts have given no further trouble.

These are only two cases which I have described, because they have just occurred, and they point quite clearly to the powerful influence that belladonna has in modifying the secretion of milk. Of course, one might say that, after a few days, the breasts settle down of themselves to their work. Sometimes they do, and sometimes they do not. My observation points to the fact that poor women, of their own accord, fly to a hundred remedies to relieve them—seidlitz powders, castor oil, rubbing with oil and various things, and exhausting the breast with some kind of apparatus, and frequently to no effect; and frequently, also, with no result, is belladonna applied externally. The worst suppurating breast ever I saw was one in which the extract of belladonna had been applied most faithfully. In fact, applied externally in any form, belladonna is most disappointing. It frequently fails to relieve pain, take out the heat, or reduce the secretion of milk; and the cleanest of its applications is dirty. The smell, too, is frequently exceedingly offensive to the patient. Belladonna given internally is at once cleanly and effective; and I believe that, administered with judgment and careful watching of its effect, it is a specific for such congested conditions of the mammary organs.

Latent Vesical Calculus.

Before the West London Medico-Chirurgical Society (*Med. Times*, June 13), Mr. Fenwick pointed out that stone in the bladder was frequently overlooked because calculous symptoms were absent owing to (1) anæsthesia of the mucous membrane

of the bladder, well exemplified in a case mentioned in Deschamps' "*Traité de la Taille*," Vol. I., p. 166; or (2) mechanical causes preventing the stone falling upon the sensitive neck of the bladder. These mechanical conditions were of three kinds—(1) adherence of the calculus to the walls of the bladder; (2) sacculation of the bladder wall (both rare conditions); and (3) pouching of the *bas fonds* of the bladder. He drew attention particularly to this last cause, which was generally supposed to be a condition inherent in old age as a consequence of enlarged prostate, but which was also produced by stricture of the urethra in the adult. It consisted in the hypertrophy of the muscles of the ureters, commonly known as the muscles of Ellis, which cross the base of the trigone from ureter to ureter. The *bas fond* is pouched behind this ridge or bar, and the small pool of stagnant urine which collects there tends to produce or augment the size of a stone, like the similar collection in the pouch of the aged bladder behind an enlarged prostate. Moreover, it is obvious that this ridge is as able to prevent the stone contained in such a pouch from galling on the neck of the bladder as is an enlarged third lobe of a prostate. A case illustrating the latency of stone due to this cause was then detailed, and the bladder with the above-mentioned ridge or pouch exhibited. It had been removed from a man, aged 35, who had suffered for eighteen years from traumatic stricture, and had been under notice for the last nine months for chronic cystitis, stricture, and right-sided nephrosis. A month before his death he exhibited symptoms of calculus, and was immediately sounded. A large stone was discovered and removed at one sitting, weighing 1 $\frac{3}{4}$ ounces; he died fourteen days after the operation. Mr. Fenwick mentioned that four out of thirteen cases of calculus which had passed through his hands during the last quarter fell into the category of latent stone. In one of these four cases a stone weighing over a pound and a half had been successfully removed by his colleague, Mr. Rivington.

Mr. Swinford mentioned a case he had seen when at University College Hospital, where lithotomy had been decided upon, but at the moment of operation it was abandoned, as the stone could not be felt. The patient died soon after, and a stone was found encysted in his bladder.

Dr. Thudichum mentioned that encysted calculi were generally of renal origin. He reproached surgeons with not paying sufficient attention to the medical side of their cases, and it was to be attributed to this that so little was known as to the causation of stone.

Mr. Bruce Clarke quoted a case where the symptoms of stone only presented themselves when from any cause the urine ceased to be acid, and became alkaline; further, the symptoms were oftener in abeyance with uric acid calculi.

Dr. Campbell Pope mentioned the case of an infant at whose birth he was present, who did not pass any water for the first two days, and who, notwithstanding all efforts made to relieve it, died subsequently, and where at the post-mortem both ureters were found to be quite impervious, thus showing at what an early age the causes of stone might begin.

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—In a reprint entitled "The Latest Systems of Medicine," Dr. J. C. Reeve, of Dayton, Ohio, gives a valuable historical review of the rise and fall of special systems in medicine. In passing, he touches up the homœopaths and the bacillo-maniacs.

—Prof. J. B. McConnell, M. D., of Montreal, has published a useful pamphlet on cholera, giving a great deal of information, in small space, about its nature, symptoms, history, causes, and prevention.

—The obscure subject of hydatid tumors in the brain is handled in an interesting manner in a pamphlet before us by Dr. R. Harvey Reed, of Mansfield, Ohio.

—Messrs. Cupples, Upham & Co., of Boston, have published in handsome form a pamphlet of twenty four pages by Dr. Buckminster Brown, entitled, "Double Congenital Displacement of the Hip; Description of a Case, with Treatment Resulting in Cure." It is accompanied by several well-executed photographic plates, and the case is certainly an extraordinary one, and worthy of this careful description.

BOOK NOTICES.

Eighth Report of the State Board of Health of Wisconsin. Pp. 158. Madison, Wis. 1885.

This volume contains the general report of the Board, that of the Secretary, extracts from correspondence, a rather premature announcement of the contagion of consumption, an article on milk by Prof. Daniels, and one on the conduct of funeral services in death from contagious diseases by Rev. E. Corwin.

The Technology of Bacteria Investigation. Explicit directions for the study of bacteria, their culture, staining, mounting, etc. By Charles S. Dolley, M. D. 8vo., pp. 263. Price, \$2.00. Boston, S. E. Cassino & Co., 1885.

To many investigators this work will be a welcome aid in their researches. It begins with directions for microscopical preparations and culture experiments, and for experiments in vaccination or inoculation. A second part is devoted to the special methods for investigating pathogenic bacteria, as those of anthrax, cholera, glanders, syphilis, tuberculosis, etc., including all the diseases which owe, or are imagined by some to owe,

their origin to bacteria. In the last part are given a large number of recipes for the preparation of preserving and staining fluids, and other formulæ of service to the microscopist.

As a hand-book in investigations of this character, it appears to us to be the most complete which has yet been issued on this side of the Atlantic.

The Treatment of Opium Addiction, by J. B. Mattison, M. D. 8vo., pp. 49. Price, 50c. G. P. Putnam's Sons, New York.

The author details his method of breaking up the opium habit, and claims that it is vincible in all cases where not connected with organic disease. The monograph is an enlargement of a paper read before the American Association for the Cure of Inebriates.

Elements of Modern Medicine, Including Principles of Pathology and Therapeutics, with many useful memoranda and valuable tables for reference, by R. F. Stone, M. D., etc. D. Appleton & Co., N. Y.

As indicated by the title, this is an epitome, compendium, or remembrancer, for the student and physician. It is printed in small type on thin paper, and bound like a pocket diary for convenience of carrying. For those who need this sort of book, it can be recommended as carefully prepared, and containing a great deal of matter.

Diseases of the Tongue. By Henry T. Butlin, F. R. C. S. Pp. 451.

Comparative Anatomy and Physiology. By F. Jeffrey Bell, M. A., etc. Pp. 555. Lea Bros. & Co., Philadelphia.

These two excellent works are parts of the "Clinical Manuals for Practitioners and Students of Medicine," issued in Great Britain and published in the United States by Messrs. Lea Bros. They are exceptionally excellent in composition, convenient in size, well illustrated and printed, and nicely bound in cloth.

The two volumes before us are fully equal to their predecessors, and will be found a valuable addition to a medical library.

Cancer: A Study of 397 Cases of Cancer of the Female Breast, with clinical observations. By Willard Parker, M. D. 8vo., pp. 73. Price, \$1.50. G. P. Putnam's Sons, New York city.

The editor, the son of the late Dr. W. Parker, informs us that this monograph was the last medical study of his father, and it was his wish that it should be published. It is certainly a valuable record, and with its full tables and sound suggestions for treatment will aid the practitioner materially in combating this dire disease.

THE
Medical and Surgical Reporter,
 A WEEKLY JOURNAL,
 ISSUED EVERY SATURDAY.

D. G. BRINTON, M. D.,
JOSEPH F. EDWARDS, M. D., } EDITORS.

The terms of subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	\$5.00
Quarterly Compendium of Med. Science, -	2.50
Reporter and Compendium. - - -	6.00
Physician's Daily Pocket Record, - - -	1.50
Reporter and Pocket Record, - - -	6.25
Reporter, Comp. and Pocket Record, - - -	7.00

For advertising terms address the office.

Marriages, Deaths, and Personals are inserted free of charge.

All letters should be addressed, and all checks and postal orders drawn to order of

D. G. BRINTON, M. D.,
 115 South Seventh Street,
 PHILADELPHIA, PA.

THE
QUARTERLY COMPENDIUM
 OF
MEDICAL SCIENCE.

The attention of our readers is especially called at this season to the **QUARTERLY COMPENDIUM**, which we publish.

It is, in fact, a supplement to the **REPORTER**, being made up of articles which have not appeared in the weekly, but yet are of value and interest to the physician.

It contains about 150 pages of reading matter in each number, and the whole four numbers, embracing 600 pages of choice material, will be sent to paid-up subscribers to the **REPORTER** for the very moderate price of

ONE DOLLAR,

in advance, for the year.

Address **DR. D. G. BRINTON,**
 115 South Seventh Street,
 PHILADELPHIA.

THE FAILURE OF THE VIVISECTION BILL IN PENNSYLVANIA.

The Pennsylvania branch of the American Society for the Restriction of Vivisection has lately distributed several tracts and pamphlets in pursuit of its aims, and to influence the public in favor of its efforts. One of these is entitled "Facts in regard to the failure of the bills presented to the Legislature for the restriction of vivisection." The brunt of this statement bears heavily on Drs. H. C. Wood and S. W. Mitchell. They are accused of having promised the Society to support a bill which, before the legislative committee, they threw cold water upon.

A careful reading of the "statement of facts"—and we have not sought other sources of information—will easily explain the position assumed by these gentlemen. Both of them, and for that matter all physicians, are perfectly willing to support a bill restricting vivisection, provided that a sensible restriction being admitted, the matter will end there, and no further agitation be begun to do away with it altogether. This was the assurance Dr. Mitchell asked, and that the Society did not give. They say their committee was not prepared for the question. We ask, are they prepared now to give an affirmative reply? We have good reason to know they are not. We have excellent authority for saying that the Society intend to continue to agitate and appeal, with the hope of abolishing vivisection entirely. This is evident from their pamphlets, as well as their spoken utterances. Their name, "for restricting vivisection," is merely a disguise for their real intentions, and not an honest intimation of their final purpose.

Such being the case, all must approve of the action of the gentlemen named. They did not intend to commit themselves to the projects of a society which declined to express its real designs, and merely wanted to use them as stepping-stones to results which they condemned.

While disapproving of causing unnecessary pain to any organic creature, we acknowledge but little sympathy with the sentimental affection for brutes now so prevalent. To a well-ordered

mind no sight is less pleasing than to see a woman fondling and kissing some ugly cur of high degree, when her own children are lacking in physical or moral education, or when she is taking nightly precautions not to have children—and this sight is no rare one in our civilization.

THE FUNCTION OF THE THYROID GLAND.

Most works on physiology pass over the thyroid gland with a very superficial mention. It is said to exercise some part of importance in foetal life, no one knows what. In extra-foetal life it is said to partially atrophy, and to be merely a useless organ to the adult—rather worse than useless, as in goitre it becomes inconvenient, and sometimes dangerous.

This shows how little we know about human physiology. Recent researches have shown that the thyroid gland has an intimate and all-important relation to the highest functions of man, those of his brain. This fact was first developed by the extirpation of the gland in goitre, a proceeding which, according to the received views, ought to be wholly indifferent to the economy. Such is far from the case. After the total extirpation of the gland, the subjects steadily lose their mental vigor; the features become heavy; the speech slow and dull; the muscular system weakens, and the skin turns rough, thick, and hard; in short, a condition gradually supervenes strikingly like that called by Charcot *myxœdema*, or the pachydermatic cachexia. They become cretins.

If ever so little of the gland remains, it is sufficient to prevent these changes; but its complete removal surely entails them. Experiments on dogs and cats yield similar results. The animals do not long survive, but are attacked with convulsions, somnolence and paralysis, which prove fatal.

Two theories have been advanced to explain these changes. One is that of Liebermeister, who maintains that the thyroid gland is the regulatory organ of the encephalic circulation, and that its abstraction throws this into chronic disorder.

The other is that of Prof. Bruns, of Tübingen. He believes that the thyroid is either a depuratory gland which excretes certain substances poisonous to the nervous system; or that it fabricates certain substances indispensable to nervous vigor—which of the two he is uncertain.

The very important practical conclusion remains uncontested, that in all operations for goitre, a small portion of the gland should be allowed to remain.

POISONOUS QUALITIES OF SULPHUROUS ACID.

In indigo manufactories and straw-bleaching establishments, and in similar institutions, it has long been known that the air impregnated with the vapors of sulphurous acid is very injurious to inhale. But the question, what percentage of admixture of the acid to the atmosphere becomes dangerous to the human being, though settled long since with reference to carbonic oxide and carbonic acid, has never been determined as regards sulphurous acid.

Dr. Masonori Ogata, in Japan, has recently inquired into this point, and published the results of his researches in the *Arch. f. Hygiene*, Bd. ii., Heft. 2, 1885. These investigations took place under the supervision of v. Pettenkofer. Air containing one-twentieth of one per cent. of the acid can no longer be inhaled without injury.

The effect becomes apparent mainly in the blood, sulphurous acid being a virulent blood-poison. The animals experimented upon did not die from want of O, but from the presence in the blood of a CO hæmaglobin, entirely foreign to the normal composition of the circulating fluid. Corpuscles whose O has been taken up by the SO₂, and which contain therefore SO₃, even in very minute quantities, act as poisonous agents.

In recent times disinfection of the atmosphere with sulphurous acid has been recommended in some epidemics. While unquestionably effectual, its application will have to be practiced with care, by reason of the facts above elucidated.

NOTES AND COMMENTS

Cerebro-Spinal Fever.

The experience of physicians in our country seems to be in favor of opium as the main remedial agent in epidemic cerebro-spinal meningitis. To be effective it must be given as early as possible, by all means before the symptoms of plastic effusion appear, and in decided, even heroic doses. Still some cases will die. But Dr. Lange, of Stettin, published a peculiar treatment of his own in the *Allg. Med. Centr. Zeit.*, May 6, 1885. He tried this treatment during the epidemic of 1864, and again in 1884, and found it so uniformly successful, that he recommends it as a specific cure for this dangerous malady. The records of a considerable number of cases accompany the report. Although Lange's article is the leading one in the celebrated German medical journal (one of the best, oldest and most reliable in Germany), and although the article makes at least partly the impression of the writer's sincerity, the uniformly favorable result in this grave disease causes us to doubt the correctness of the author's diagnosis in every case. We do not think that he intends to deceive us, but we have the suspicion that he has himself been deceived. And yet he may be right, and for this reason alone we publish in the following his method of treatment:

First, especially if the vomiting is intense, when the *sod. bic.* is increased in dose, L. administers:

R. Magnes. ust.,	5 i-gr. lxxx.
Cupri oxid. nigri. p.	gr. iiii.
Aquæ nicotian. destill.,	f. 3j.
Aquæ destillat.,	f. 3v.

M. S.—First every hour, then every two hours, a tablespoonful.

Then:

R. Sod. bicarbonatis,	5 ijss.
Tragac.,	gr. v.
Aqua destill.,	f. 3v.
Aqua nicotian. destill.,	f. 3j.
Cupri oxid. nigr. p.,	gr. iiii.

M. S.—Same as first. And:

R. Tinct. cupri acet.,	f. 5ss (mxxx.)
Aq. nicot. dest.,	f. 3j.
Aqua cinnamomi, mucil.	
gm. mim.,	āā f. 3ss.
Aqua destill.,	f. 3iv.

M. S.—A tablespoonful every two hours.

The first (magnesia) mixture is generally administered but once; as soon as its purgative action has been established, the bicarbonate of sodium mixture is substituted. (The fact mentioned alone causes us to doubt L.'s correct diagnosis, for in true cerebro-spinal fever the bowels are not thus easily moved.) "If constipation was

not present," (?) continues the author, "then two bottles of the bicarbonate mixture are given, and with them the indication for the alkalines, which is never absent, is sufficiently fulfilled. Then the last mixture, containing tinct. cupri acet. is administered, and this is continued for some time after all symptoms have disappeared, as otherwise a relapse is apt to occur. (!?) How rapidly the doses should follow each other the severity of the case must determine."

Again, very peculiar are the concluding remarks of the author, Headnits, that he believes in the infectious nature of the disease. He also acknowledges that neither copper nor tobacco are germicides, but thinks, as in other cases, it has also been shown that the destruction of the germs is impracticable, that the fact of copper, etc., not having that effect would be proof of the correctness of his views. "For," he concludes, "it is only necessary to preserve to the affected organs their normal power of resistance, and the remedies mentioned evidently effect this desirable result."

How copper and tobacco can preserve the power of resistance, normally lodged in the brain, is more than we can comprehend.

In one of the cases reported by L. he did not see the patient until all the symptoms, which had been very mild in this case, had ceased, only the deafness remaining. "But," L. says, "convalescence set in, only the deafness did not improve, though I do not doubt that this also disappeared." As all the symptoms had already ceased when the case came under L.'s charge, convalescence must have been established ere L. saw the case; and how L. can suppose that the deafness left of its own account, without his having the slightest proof for it, is the more peculiar, as it is well known, whatever other sequelæ of this frightful disease might later yield to treatment, deafness is the one which never improves.

For some unexplained reason there may be some virtue in L.'s treatment, and considering the fatal character of the malady, it may be worth while to try L.'s method. But if he is as unreliable and shaky in his diagnosis as he is in his other statements, we do not promise ourselves any success with his treatment.

Syphilitic Infection.

A series of lectures on syphilis, by M. Leloir, of Lille, is appearing in the columns of the *Progres Medical*. M. Leloir has collected a large number of cases where chancres have appeared in unusual situations, and in all these cases there was evidence both that the epidermis was denuded

from the site of the chancre at or before infection, and that syphilitic virus was deposited on the denuded spot. The natural arrangement by which the tissues of the vagina are capable of great distension without rupture, and considerable friction without laceration, account for the rarity of vaginal chancres. Anal chancres have been repeatedly observed in women who have subjected themselves freely to natural coitus when suffering from slight fissure of the anus, infected fluids running harmlessly over an unexcoriated vulva and perineum, to find a nidus in a fissure. The great frequency of fissure in the anus, in women with neglected gonorrhœa, is well known. M. Leloir described cases of infection through eczematous patches on different parts of the body. There is strong evidence that syphilitic virus has lain on an uninjured epithelial surface for some time without infecting the subject. On the other hand, there is still stronger evidence of a very serious fact, which proves that cleanliness alone will not always protect the profligate and the careless from syphilis. When syphilitic virus falls on a surface denuded of its epithelium, absorption is instantaneous, and resists the most rapid preventive measures. A surgeon, who had just grazed his finger, observed, in examining a syphilitic patient, that the excoriation touched, for a second, the surface of a chancre. He scrubbed the finger thoroughly with soap and water at once, but all in vain, for in a few weeks a chancre appeared on the finger, and was followed by constitutional syphilis of the severe type often seen in such cases. Several precisely similar cases have occurred amongst British practitioners. M. Leloir believes that early cauterization may destroy the virus, but states that this theory has not been thoroughly proven. He lays great stress on the fact that a hard sore undergoes a long period of incubation. "Never has a chancre, the first sign of a reaction of the organism against the syphilitic virus, shown itself on the first day, nor on the second, nor on the fourth, nor even during the first week." M. Leloir gives the twenty-fifth day as the medium date. By unjustifiably allaying the apprehensions of a patient too quickly, he may be induced, as has not unfrequently happened, to look upon a chancre that has appeared very long after infection as a mere excoriation, and, on the strength of his error, he may spread infection to others. M. Leloir has observed the "premonitory herpes" of Cusco, a crop of herpetic vesicles sometimes appearing on the prepuce two or three days before the chancre, and possibly due to irritation of the nerves of the

skin by the virus. This complication may, obviously, be a source of fallacy in a patient who persists in excesses after actual syphilitic infection.

Pyridine.

From a foreign exchange we learn that M. Germain Sée, in a communication to the Académie des Sciences on pyridine, states that neither subcutaneous injections of pyridine salts, nor smoking cigarettes of pure pyridine, offered the same advantages in asthma as the practice of administering it by inhalation. Four or five grammes are poured onto a plate, which is placed in a closed room containing rather less than twenty-five cubic metres of air. The patient, in the room, breathes the air impregnated with pyridine. This treatment should be repeated, for about twenty minutes, three times a day. Pyridine can be traced in the urine almost immediately after the commencement of an inhalation. According to Dr. Germain Sée, hypodermic injection and pyridine cigarettes provoke nervous disturbance. Inhalation produces a beneficial effect; the feeling of oppression common among asthmatic patients being relieved, breathing becomes easier, and they have no longer the characteristic intense longing for fresh air. The sensibility of the pneumogastric nerve and the excitability of the medulla are considerably diminished, and the heart's action becomes normal. It frequently happens that the patients fall asleep after the inhalations. This sleep is almost normal, and is not accompanied by profound insensibility, and is, therefore, different from that provoked by anæsthetics. While it lasts, sensations, followed by reflex phenomena, are provoked with difficulty, although contractile energy is maintained. The administration of pyridine is not followed either by paralysis, convulsions, or tremors; but the muscles are relaxed, and temporarily lose their tonicity, in consequence of the lessened sensibility of the medulla oblongata and spinal cord. This modification of reflex sensibility is the special characteristic of pyridine, as distinguished from substances like nicotine and atropine. All the patients to whom Dr. Sée administered pyridine had quiet nights, though previously tormented with violent fits of coughing and intense oppression. The physical pulmonary symptoms all showed improvement. Pyridine does not affect the general health. When the suffocating asthmatic fits reappear after inhalations for nine or ten days, Dr. Sée recommends the administration of iodides. He has treated fourteen patients, nine of whom were asthmatic,

and five subject to cardiac disease; they were all relieved. One patient had suffered from asthma for twelve years; he was greatly relieved by the treatment with pyridine, but it was discontinued in consequence of troublesome attacks of vertigo and sickness. The asthmatic patients who presented cardiac and renal complications, declared that respiration was much eased by the inhalations. Dr. Sée concludes that pyridine is preferable to hypodermic injection of morphia, its action being preferable and less dangerous.

A Study of the Subject of Spontaneous Rupture of the Membranes at Full Term of Gestation Preceding the Beginning of Labor.

Dr. G. W. H. Kemper, of Muncie, Ind., in the April issue of *The American Journal of the Medical Sciences*, offers a careful study of fifty cases of spontaneous rupture of the membranes, occurring in his first 700 obstetrical cases, and he finds that—

1. The spontaneous rupture of the membranes at full term of gestation, and preceding the beginning of labor-pains, is an event of common occurrence, averaging about once in every fourteen labors.

2. When the membranes are broken, as a rule, labor supervenes at once, or within the next four hours, but may be delayed several hours, days, or even weeks.

3. When such an accident occurs, the duration of the labor is not necessarily prolonged, nor rendered more painful.

4. The mortality of the mothers is not augmented, and the ratio of still-born children, if at all, is so slightly increased as to amount to a minimum.

5. The causes are not well defined. The repetition of the accident in certain women shows that with some a tendency is inherent. A possibility of atmospheric influences, especially a low temperature, as an exciting cause, is admissible. Smellie considered obesity a cause. His observations have not confirmed this statement.

6. It is probable that the duration of labor is shorter in cases where the appearance of pains is delayed for some time after the membranes are ruptured.

7. The proper plan of treatment, as given by Smellie, McClintock, Bard, Denman, and Dewees, and corroborated by Dr. Kemper's experience, is rest, if necessary in a recumbent posture, and patience. All efforts to excite labor-pains are hurtful, meddlesome, and mischievous. Wait for pains, and treat the case on general principles!

8. Finally, that the fear of delay and danger in this class of cases—the classical "dry labor"—promulgated by our early obstetrical fathers, and indorsed by successive authors generally, is based on a merest spark of truth, and is one of those medical traditions that experience shows to be over-estimated and to a large degree apocryphal!

Conservative Ovariectomy.

From a foreign exchange we learn that Professor Schatz, of Rostock, has described in the *Centralblatt für Gynäkologie*, June 6th, a highly interesting case of pregnancy following double ovariectomy performed after a plan recently advocated by Schröder. On February 20, 1880, Dr. Schatz removed from a girl aged 20 a large cystic tumor of the left ovary, including the outer third of the Fallopian tube, and all the ovarian tissue. The right ovary was distinctly enlarged and cystic; it was ligatured by means of three silk threads passed between it and the broad ligament, and cut away in such a manner as to leave a piece of ovarian tissue, hardly two millimètres broad, on the proximal side of the ligature. The right tube remained intact. An abscess formed, during recovery, in the track of a suture in the abdominal wound. On March 21st, when the period was due, severe pain was felt on the right side of the hypogastrium and right thigh, with vomiting and fever. The symptoms recurred on April 8th and May 8th. No deposit could be detected in the pelvis. The first "show" appeared on May 9th; it lasted three days, and was pale and scanty. It recurred on May 31st. In the interval, there were attacks of pain in the left groin. On June 11th, a swelling of the size of a plum was detected behind and to the left of the uterus, which was strongly anteflexed. On June 28th, severe sacral pain set in; it radiated to the left inguinal region, and disappeared at period, which was copious, and lasted for six days. On July 15th, the uterus was found to be small and retroverted. The catamenia thenceforward appeared regularly till the patient's marriage in April, 1884. She became pregnant in September, and was delivered on May 12th of this year.

Case of Recovery from Malignant Pustule.

Dr. W. E. Buck thus writes in the *Brit. Med. Jour.*, July 4:

Mr. F., aged 31, a veterinary surgeon, experienced on October 6 a stinging sensation at the back of the right wrist. A small bleb was formed, which he scratched off, and there was some ten-

derness of the elbow and arm-pit. He had a slight rigor. On October 8, he was seen by Dr. Meadows, who prescribed some salicylate of soda and tincture of aconite, in frequent doses, as his temperature was 104°, and the rigors continued almost the whole of the day. A black eschar began to form on the afternoon of the 8th, and on the 9th it became about the size of a sixpence; its base was red and oedematous, and surrounded by some vesicles in a circular shape.

The temperature was nearly 104°; the patient felt cold, and his tongue was foul. I visited the case with Dr. Meadows, and we injected pure carbolic acid under the eschar, using an ordinary hypodermic syringe. Unfortunately we could only introduce a small quantity, as it oozed out in the withdrawal of the syringe, and with it a serous-looking fluid. I dried some of this fluid on a cover-glass, stained it with methyl-violet, and found the well-known bacilli of anthrax. We prescribed large and frequent doses of soda-hyposulphite, and ordered also a large quantity of meat. Under this treatment he rapidly improved.

On October 12, we again injected carbolic acid. The temperature came down, and, as the patient said he felt all right, the hyposulphite of soda was reduced to three times a day. The eschar did not finally separate for nearly six weeks, and the ulcer then soon healed. I believe that the main remedy in this case was the injection of pure carbolic acid, a mode of treatment which does not seem very painful.

There was a clear history of the disease, which was contracted exactly twelve days before its first appearance. Mr. F. having examined the flesh of an animal that had died from anthrax.

A Contribution to the Pathology of Malarial Fever.

Drs. W. T. Councilman and A. C. Abbott, of Baltimore, report, in the April number of *The American Journal of Medical Sciences*, two cases of malarial coma, with post-mortem examination, of especial interest in connection with which was the presence of small hyaline masses in the brain and elsewhere. The authors fully consider the arguments pertaining to the supposition that these hyaline bodies are living organisms, without being able to arrive at any definite conclusion.

With a view of shedding some light on the subject of lower organisms in malaria, they made a careful search for the bacilli of Klebs and Tommasi-Crudeli, and for many other lower organisms, in all of the cases of malarial fever which came under their observation on the post-mortem table.

In no case were any bacilli, bacteria, or micrococci found. Only in the two comatose cases, which they have fully described, were the singular hyaline bodies found.

This is an argument against the probability of these hyaline bodies being micro-organisms. They cannot suppose the comatose form of malarial poisoning to be a special disease, and were a lower organism found in this, it should also be found in other cases.

Digital Tenotomy in Pianists.

The operation devised by Dr. Forbes, of this city, Dr. Noble Smith, of London says, in the *Brit. Med. Jour.*, July 4, 1885, promises to be one of great benefit to accomplished pianists, as well as to learners. In making some dissections on the dead body, with a view to determine the usual position of the slips of tendon which limit the action of the extensor of the ring-finger, he found that these vary very much in different cases; so that it becomes necessary to carefully determine their position by the eye and finger, during movement of the extensor-tendon, in each case before operation. He has just succeeded in freeing the ring-finger of the right hand of an accomplished lady pianist, without causing her much more pain than is felt from the prick of a needle. Before operation, she was able to raise the finger only five-eighths of an inch beyond the others. Directly after operation, she could raise the finger easily to one and a half inches, without the least feeling of loss of control over its action. The division was, of course, made subcutaneously, so that only a minute wound was left in the skin, one-eighth of an inch in length.

Laryngeal Hemorrhage.

The name laryngeal hemorrhage is used for a variety of affections which differ widely in regard to cause, nature of the disease, and severity of the symptoms, and have in common only the effusion of blood into some part of the larynx.

Dr. J. W. Gleitsmann, of New York, in a paper in *The American Journal of the Medical Sciences* for April, proposes to designate by the name laryngitis hæmorrhagica, such effusions of blood on the free surface, or under the epithelium of the mucous membrane, which are of a so-called idiopathic character, and not due to any constitutional disease or traumatic origin. He records a case of this character, and analyzes those that have been heretofore recorded. He finds that in exceptional cases only is hemorrhage from the larynx a precursor of phthisis.

Report of a Case of Partial Pylorectomy.

Dr. J. M. Spear, of Cumberland, Md., reports, in the *American Journal of the Medical Sciences* for April, 1885, a case of partial pylorectomy in a blacksmith, aged 40, who suffered from cicatricial stenosis of the pylorus. The operation was a modification of Billroth's, and required one hour and a half for its performance. The tumor was not adherent. Death ensued in two and a half hours, from collapse. In the opinion of Dr. Spear the case was an eminently proper one for operation, but it should have been performed at an earlier period in its history.

CORRESPONDENCE.

A Case of Aconite Poisoning.

EDS. MED. AND SURG. REPORTER:—

I was called to treat a case of pneumonia in a robust adult male. I prescribed aconite to lower arterial action. The pulse was frequent and bounding, and forty-eight drops of Fleming's tincture of aconite root was left in a glass of water to be taken in twelve doses. The nurse, in mistake, gave this mixture for a glass of lemonade which she had just prepared. The mistake was immediately discovered, and I was called again within a few minutes after the ingestion of the poison. I at once resorted to all the available emetics at hand, and alternately gave mustard and tepid water and thirty-grain doses of ipecac. Vomiting and purging was produced in twenty-five minutes. The patient complained of giddiness and quivering of the muscles; also the characteristic tingling. The pulse was now imperceptible. The respirations shallow and frequent. I gave a hypodermic syringe full of brandy, which brought back a feeble, irregular pulse for a few minutes, and the drug showed its depressing effect more marked than ever. The skin was cold and sweaty; the countenance livid and anxious, while the purging and vomiting continued. I informed the family of the serious condition of the patient, and Dr. G. A. Parker, of Southampton, Pa., was called for consultation.

During this time I repeated the hypodermic injections of brandy every few minutes, which seemed to sustain the heart for a very few minutes only. Ammonia was added with good effect for awhile. The pulse would gain and sink lower and lower. Thirty minims tr. digitalis was added to the injections of ammonia and brandy, and repeated alternately at intervals of five to ten minutes. This last addition had also a happy effect. The systole of the heart was perceptibly strengthened, and the patient revived for a time under its use.

Notwithstanding all this, the poison still gained its power, and by the time that nine hours had elapsed, the patient seemed in a hopeless condition. A mustard plaster was placed over the cardiac region. Bottles of hot water, and flannels soaked in hot whiskey were placed about the cold extremities. No arterial pulsa-

tions could be felt in them, and we could not detect any heart sounds on auscultation over the chest. The patient was conscious, with contracted pupils and a livid, sunken countenance. The respirations were very frequent, but the voice and sensation were not lost. At this time twelve hours had passed from the ingestion of the drug. The purging and vomiting having now ceased the remaining half-pint of hot brandy was injected into the rectum, and the patient was left for an hour.

Dr. Parker returned to the room, and found a faint radial pulse. It seems that by this time the stimulants had gained sway over the poison, and with renewed efforts the patient was on the road to recovery, which was complete, and the man is now well.

O. C. ROBINSON, M. D.

Huntingdon Valley, Pa.

Blue Lick Water in Treatment of Lichen.

EDS. MED. AND SURG. REPORTER:—

Three years ago this summer I was consulted by a man about fifty years of age, a native of England, and who had been a resident of this country for not more than a couple of years. He declared himself as driven well nigh to desperation by the intolerable itching attendant upon his malady, which was plainly a most aggravated example of *Lichen Ruber*. The characteristic papular eruption covered the thorax, abdomen, genitalia, thighs, backs of hands, and face. None of the lotions, washes, etc., he had ever used had afforded much relief, and the same he stated to be true concerning internal remedies, of which he has taken great quantities. He further mentions a fact that at the time did not convey to my mind the valuable suggestion it contained, namely, that drinking of the waters of the Harrowgate Springs, of Yorkshire, was the only agency that had ever brought him any substantial relief. I should mention that the beginning of the symptoms dated back some four or five years, and occurred only during the warm season. All the points in the history of the case were not noted at the time, but I have same vague recollection of a history of rheumatism preceding the first attack of the eruptive disorder.

I prescribed alkaline treatment with arsenic; and locally, a carbolyzed ointment. The use of these was persisted in for some time, with no resultant benefit. One day, during the recital of a most unsatisfactory account of his condition and symptoms, he ardently expressed the wish that Harrowgate was accessible. The idea then occurred to me to look into the composition of this mineral water, in the hope of finding an American water of similar composition and properties. It required but little research to discover a marked similarity between the Harrowgate and the Blue Lick of Kentucky. They compare as follows:

Harrowgate.

Chloride of sodium.
Chloride of magnesium.
Chloride of calcium.
Chloride of potassium.
Carbonic acid gas.
Sulphuretted hydrogen.
Sulphohydric acid.

Blue Lick.

Chloride of sodium.
Chloride of magnesium.
Chloride of calcium.
Chloride of potassium.
Sulphates.
Sulphuretted hydrogen.
Iodides.
Bromides.

It will be observed on comparison of the above, that they are essentially identical in composition, and the inference of their meeting the same therapeutic indications is a most rational one. At any rate, I prescribed Blue Lick water. The effect was prompt and gratifying. The eruption rapidly subsided, and the patient's condition was soon changed from that of great misery to comparative comfort. The circumstances of my patient were not such as to permit of his visiting the springs and partaking liberally of the water. For a time he purchased it in small quantities of the local druggist, but afterwards procured it by the barrel direct from the springs. This he does with the recurrence of the warm season, and is thereby enabled to live in some measure of enjoyment. The quantity he is using this season is half a gallon per day. This amount keeps the disease effectually under control. I see much reason to believe that a thorough and extended course of treatment at the springs would effect a thorough eradication of the ailment.

Of course, I have not concluded that this is the treatment for all cases of lichen. There are cases that prove very rebellious to this and all other plans of treatment. As a general principle, it may be stated that the most promising treatment of lichen ruber is the arsenical. Lichen planus calls for alkalies and tonics. The history of rheumatism in my patient may explain the action of the mineral water in lichen ruber. This is the fourth season he has used it. It is his sole dependence in the way of treatment, the effect never failing in promptness and efficacy.

JOHN J. THOMAS, M. D.

Youngstown, Ohio, July 28, 1885.

How to Take a Pill.

EDS. MED. AND SURG. REPORTER:—

Dr. H. Asthalter, in his note to you, "How to Take a Pill," tells of a very difficult way of linguaglutition, or deglutition. One cannot easily take a pill that way. Try it. In drinking, the tongue does not "curve back upon itself." Only after the liquid has passed the epiglottis is the tongue drawn back, curved by an involuntary nervous influence. Besides, you have the disagreeable taste of the pill—the thing patients complain most of. Tell this way of my own, that I have used for many years, and many will be happy among our children, who are the most difficult pill-eaters.

First, I tell the patient (and this is the important step) to take a large mouthful of water (I wonder what your correspondent means by "other liquid" in his note—something to disguise the taste?); throw his head back and swallow; this opens and clears the oesophagus from sticky, thick mucus. Then take another large mouthful of water, throw the head back—away back—drop the pills in, and swallow, and you have a straight road to the stomach, not a curved one.

I have never any trouble. I have heard of the "under the tongue" way. It is only a popular fallacy.

WILLIAM M. OGDEN, M. D.

520 Shawmut Avenue, Boston, Mass.

NEWS AND MISCELLANY.

Lehigh Valley Medical Association.

Fifth annual meeting of this Association will be held in the National Bank Hall, Quakertown, Pa., Wednesday, August 19, 1885. The profession is cordially invited to attend the sessions of the Association.

PROGRAMME.

MORNING SESSION—10:30 O'CLOCK.

1. Roll call.
2. Address of welcome, Joseph Thomas, M. D., President of the Association.
3. Appointment of a Nominating Committee.
4. New business (including report of Executive Committee, of the Treasurer, and election of members).
5. Unfinished business (including action upon proposed revision of constitution and by-laws).
6. 11:30—Special hour.

Address, "Proper Organization of Local Boards of Health," Benjamin Lee, M. D., Secretary State Board of Health.

Recess for dinner.

AFTERNOON SESSION—2:30 O'CLOCK.

1. Report of Nominating Committee.
 2. Unfinished business.
 3. 3 o'clock—Special hour.
- Address, "The Treatment of Joint Diseases by Rest," De Forrest Willard, M. D., Lecturer on Orthopaedic Surgery, University of Pennsylvania.
4. Miscellaneous business.
 5. Induction of President-elect.
 6. Adjournment.

Following are the officers for 1885:

President—Dr. Joseph Thomas, Quakertown.

Vice Presidents—Dr. J. A. Horn, Mauch Chunk; Dr. J. D. Dewitt, Harmony, N. J.; Dr. C. J. Keim, Catasauqua; Dr. Amos Seip, Easton.

Secretary—Dr. Charles McIntire, Jr., 104 North Fourth street, Easton.

Corresponding Secretary—Dr. Isaac Ott, Easton.

Treasurer—Dr. Abraham Stout, Bethlehem.

Executive Committee—Dr. J. F. Wertz, Berks; Dr. A. M. Cooper, Bucks; Dr. J. B. Tweedle, Carbon; Dr. G. N. Best, Hunterdon; Dr. B. E. Stem, Lehigh; Dr. S. W. Trimmer, Luzerne; Dr. W. L. Estes, Northampton; Dr. P. F. Hulshizer, Warren.

Local Committee of Arrangements—Drs. Joseph Thomas, R. J. Lindermann, and J. S. Moyer.

NOTES.

Railroads.—The Philadelphia and Reading Railroad will issue special excursion tickets, at the rate of two cents a mile, on the 18th and 19th, good to return until August 21st. Orders for these tickets may be obtained of the Secretary.

The Lehigh Valley Railroad Company will have special excursion tickets (at same rate) for sale at Easton, Allentown, Catasauqua, Coplay, Lehigh-ton, Mauch Chunk, White Haven, Weatherly, and Hazleton, on the 19th, for Bethlehem. Tickets from Bethlehem to Quakertown must be purchased of the P. & R. agent at Bethlehem, for which the special orders must be had of the Secretary.

Dinner.—Arrangements have been made to have the Annual Dinner served at the Bush House. It is especially requested that all who are planning to come would notify the Secretary of their intention by not later than the 15th. As the person so reporting is under no pecuniary obligations

should he be prevented from coming, and as an estimate of the number expected to dine will be a great help to the caterer, it is urged that every one who hopes to be present will comply with this request.

While there will be no excursion this year, the executive committee would be glad to see the innovation of last year continued, and that the members and guests bring lady friends with them.

The executive committee will be in session in the morning, and during the recess to act upon applications for membership. Blank applications can be obtained of the Secretary.

Every one, visitors as well as members, is requested to register on arrival in the morning.

Members-elect will please also sign the constitution.

It will be a great convenience to the Secretary if the members will pay their annual fee upon registering.

DEPARTURE OF AFTERNOON TRAINS.

For Philadelphia—1:02, 3:10, 4:50, 7:26, 9:14.

For Bethlehem—3:27, 3:54, 5:35, 7:08, 9:19.

For Mauch Chunk—L. & S., 3:27, 3:54, 7:08; L. V. R. R., 3:27, 5:35, 9:19.

For Allentown, L. V. R. R.—3:27, 3:54, 7:08, 9:19.

For Reading—3:27, 7:08.

For Easton—3:27, 3:54, 5:35, 7:08, 9:19.

For Belvidere, N. J., L. & S.—3:27, 7:08. L. V. R. R., 3:54, 7:08.

For Lambertville, N. J., L. & S., or L. V. R. R.—5:38.

For Washington, N. J., L. V. R. R.—3:54.

The Health of Nomadic Populations.

The *Brit. Med. Jour.* (July 4th) tells us that the Association of Sanitary Inspectors were recently gratified with a paper, in Dr. B. W. Richardson's best manner, on a subject which, lying outside the ordinary pale of sanitary criticism, possesses greater attractions for both the lecturer and his audience. The sanitary condition and inspection of our homeless and nomadic populations are important questions, and the more important because it is no one's special business to look after them. Vagrants constitute one of the gravest difficulties, not only in the work of the poor-law, but also in that of the public health. These difficulties were not, however, the special concern of the lecturer, who defined the object of his inquiry as "to trace how far modifications of life among the homeless created varieties and extensions of disease amongst the rest of the community." There were (1) the pure vagrant, who wandered about without any provision which could be called a home, trusting to the casual ward, or any temporary shelter; (2) those who carried on an itinerant trade, and possessed a van, in which they lived and slept; and (3) the pure nomadic class, gypsies, who lived in tents, and slept on the ground in sheltered nooks, or under the brushwood of commons and moors. As to the vagrant classes, his opinion was that, while they were very helpless, by nature indolent, and by position placed in the most precarious conditions, there really was not much acute disease among them.

They lived a comparatively short life, and became prematurely old, but they were rather exempt than otherwise from many of the diseases which resulted from luxury or comfort. Zymotic diseases were rare in this class, and diseases like consumption were also rare. A very important question was the influence which these people exercised in spreading contagious diseases. At first sight, it might appear that they were the best of agents for disseminating contagion. They traveled from place to place, they were not cleanly in their habits, they often wore garments which had been thrown away by infected persons, and they became the occupants of common lodging-houses, where many people were herded together. For all this, according to his observations, they did not seem to be disseminators of disease. This is certainly opposed to general experience, and we fancy a good many medical officers of health will be inclined to traverse the accuracy of Dr. Richardson's decisions.

Amongst the itinerant hucksters, however, Dr. Richardson admitted that epidemic diseases were by no means uncommon. Their children were often scrofulous, unhealthy, and feeble, while their adults were subject to consumption. These people were also subject to other constitutional diseases, particularly those affecting the chest, asthma, bronchitis, and the various forms of disease of the heart. They—perhaps, too, more than the vagrant classes—suffered from the effects of intemperance. As to the third class—the nomadic or gipsy class—the lecturer said that he could speak from considerable experience of their manners, habits, and diseases. Gypsies were constitutionally a very healthy race; and, as far as observation upon them went, they were more distinctly free from the fatal diseases of the community than any other class, so long as they retained their original nomadic mode of life. When they began to mix and live with the people generally, they suffered like other people, although even then their diseases were rather special in character. In their out door life—living in tents—they suffered from rheumatism, which was their most common enemy, but they were extraordinarily free from the other affections. He had never heard of an epidemic of small-pox among gypsies, nor seen one of them who was pitted with small-pox, although he believed they were very indifferently vaccinated. The gypsies were not intemperate, and many of them attained to considerable longevity. From these observations the lesson adduced was that, as soon as men began to aggregate in close localities, without due and proper sanitation, and with the means of obtaining "creature comforts" too much at command, they contrasted indifferently in regard to health with their apparently less fortunate brethren, who were content to confront nature in her wildest moods. No doubt over-crowding and the aggregation of great multitudes of people in towns lies at the root of many, if not most, of the maladies which make life less endurable; and the nearer we approach to pastoral simplicity of life and surroundings, the healthier we shall be. But, human nature being what it is, we fear that not even Dr. Richardson's attractive picture will tempt the majority of people to exchange their lot for that of the vagrant or the gipsy.

Adaptation of the Dietary.

We are thus led to the next important consideration, namely, that although broad rules or principles of diet may be enunciated as applicable to different classes of people in general, no accurate adaptation to the individual is possible without a knowledge of his daily habits and life, as well as to some extent of his personal peculiarities. No man, for example, can tell another what he can or ought to eat, without knowing what are the habits of life and work—mental and bodily—of the person to be advised. Notwithstanding which, no kind of counsel is more frequently tendered in common conversation by one stranger with another, than that which concerns the choice of food and drink. The adviser feels himself warranted, by the experience that some particular combination of nourishment suits his own stomach, to infer without hesitation that this dish will be therefore acceptable to the stomachs of all his neighbors. Surely the intelligence of such a man is as slender as his audacity and presumption are large. It would not be more preposterous if, having with infinite pains obtained a last representing precisely the size and the peculiarities in form of his own foot, he forthwith solemnly adjured all other persons to adopt boots made upon that model, and on none other! Only it may be assumed that there is probably more difference between stomachs, and their needs among different individuals, than among the inferior extremities referred to for the purpose of illustration. Thus, in regard of expenditure of food, how great is the difference between that of a man who spends ten or twelve hours of the day at the work of a navy, as an agricultural laborer in harvest time, or in draining or trenching land, as a sawyer, a railway porter, or a bricklayer's laborer, or let me add that of an ardent sportsman, as compared with the expenditure of a clerk who is seated at the desk, of individuals engaged in literary and artistic pursuits, demanding a life mostly sedentary and spent indoors, with no exercise but that which such persons voluntarily take as a homage to hygienic duty, and for a short period borrowed at some cost from engagements which claim most of their time and nearly all their energies!—Sir Henry Thompson, in *Popular Science Monthly* for August.

An Heroic Cure for the Opium-Habit.

A pathetic story has lately come to my knowledge of a young man, an under-graduate in an Eastern college, who had become a victim of the hypodermic use of morphia. He went with his father, who was engaged in the lumbering interest, into the primeval forests of Maine, hoping that during a stay of months with the wood-choppers he would be able to fight out the battle of gradual abandonment successfully. Through a strange fatality, when the party had just arrived at their camping-place, and were transporting their goods across a stream, the case of morphia was broken by an apparent accident, and its contents scattered into the water. None but the haggard young man could, at the moment, comprehend the appalling magnitude of the calamity—there, as he was, two hundred miles from the nearest settlement! He survived the terrible

ordeal, but no words could express, he has said, the tortures and agony through which he passed during the succeeding weeks. He was closely watched, else, at times, he would have drowned himself or have beaten his brains out upon the rocks. Months afterward he came back to the world a skeleton, worn and haggard, from his terrible contest. It was an experience to which he could never afterward refer without the most painful emotions.

Not the least significant point in this veritable account, is the fact that the young man always believed that his father had purposely brought about the catastrophe for the sake of bringing matters to a speedy end! Has the usual treatment of the disease by physicians at this day anything to offer that is much better than this man's summary method?—From "*An Experience with Opium*," by S. T. Morton, in *Popular Science Monthly* for July.

Methods of Hanging.

The mode of carrying out the sentence of the law, "be hanged by the neck until you are dead," has usually been left to the discretion of the hangman, the law taking no cognizance as to what is to be the proximate cause of death. Calcraft invariably adopted the short drop of about two feet and a half; and if I may judge from some specimens of his ropes, which are still to be seen at Kirkdale, death must have been produced by a slow process of asphyxia. Marwood adopted what is generally known as the long drop, of which he was supposed by many to be the originator, though it was used before his time, both in Paris and in Ireland.

To Professor Houghton we are indebted for a scientific exposition of the *rationale* of the long drop, and the mode in which death takes place. Dr. Houghton also gives an elaborate explanation of the American method, which is a scientific modification of the old naval method of running the culprit up to the yard-arm.

Having now briefly referred to the different modes of hanging which have been adopted in executing criminals, we will be better able to judge which is the best and most practical method when we have considered the various causes of death. Professor Tidy says that "in hanging as in drowning, death does not always take place in exactly the same way. Thus, it may result from: (1) asphyxia; (2) cerebral hyperæmia; (3) a combination of asphyxia with apoplexy; (4) syncope; (5) injury to the spinal cord and pneumogastrics (neuro-paralytic death)."—From "*The Mechanics of Hanging*," by Dr. James Barr, in *Popular Science Monthly* for August.

Oophorectomy Run Wild.

The *Canada Med. and Surg. Jour.* says that Dr. Furber, writing from Kansas to the *Eastern Medical Journal*, says that the surgical mania of his State is spaying of women and young virgins. He says in his waking hours he often dreams of a courting scene in which the conversation runs thus: "Miss Doolittle, have you been spayed?" "Sir?" "Have you undergone ovariectomy?" "Please explain yourself, Mr. Blunt." "I desire to be informed, Miss Doolittle, whether or not

you have been oöphorectomized." "Certainly I have, Mr. Blunt. A council of regular physicians was called by my parents when I was a child, to consider the nervousness exhibited by my three elder sisters and myself, and thus oöphorectomy was performed on all four of us, by that eminent surgeon, Prof. Cassius Fitz Greene Browne, A. M., M. D. My older sisters all died, because they were not operated on earlier in life. So the doctors said, and they all agreed that where parents neglect to have their girl babies oöphorectomized, it ought to be done by the city surgeon appointed for that purpose, to prevent the thousand and one diseases that assail girls when they grow up to womanhood as their Creator made them; and they further say it should no more be neglected than vaccination, and certainly my own case proves the truth of their assertion." "I will thank you for my hat, Miss Doolittle. Good night." "Good night, Mr. Blunt."

Wells and Bacteria.

In *Science*, July 10th, we read as follows: In many towns and cities the privy-vaults and leaching cesspools of every house drain really into the sheet of ground-water. The soil arrests the coarse material, the grease and slime; but the swarming bacteria diffuse with ease, as much as the soluble chlorides and nitrates, and follow the flow wholly unobstructed. Into this same soil are sunk or driven the wells; and the water that is drawn for use is polluted in proportion to the number and proximity of the vaults and cesspools, on the one hand, and the thinness and sluggishness of the water-sheet on the other. In the worst wells in daily use the water is distinctly colored with sewage; but the most deadly water may carry only the germs of typhoid fever or of dysentery, and be otherwise sparklingly clear, and so pure as to pass unchallenged through the most searching chemical analysis.

Official List of Changes of Stations and Duties of Medical Officers of the United States Marine Hospital Service, for the week ended August 1. 1885.

Fessenden, C. S. D., surgeon. Leave extended ten days on account of sickness, July 27, 1885.

Godfrey, John, surgeon. Granted leave of absence for thirty days, July 29, 1885.

Irwin, Fairfax, passed assistant surgeon. To proceed to Richmond, Va., and Wilmington, N. C., as inspector, July 28, 1885.

Ames, R. P. M., passed assistant surgeon. Granted leave of absence for thirty days, July 27, 1885.

Illinois State Board of Health.

The Illinois State Board of Health is now engaged in revising the "Official Register of Physicians and Midwives."

Any notification of changes, omissions, or errors will be regarded as a favor, as the Board wishes to make the coming register as correct as possible.

Address, "Secretary State Board of Health, Springfield, Illinois."

Items.

—Last year the number of medical and pharmaceutical students who completed their curriculum at the Universities of Spain was 703, the total number of students graduating being 3,598.

—It is recorded in the Bombay Season Reports, that on the 27th of last December, seven shepherds lost their lives at Athni, in the Belgaum district, through being struck by hailstones of the size of a cocoanut.

—M. Crouzel has isolated a body having all the properties of an alkaloid from the mandrake (*Mandragora officinalis*). This body forms a sulphate which is crystalline. A solution of this salt was found to have marked mydriatic effects on the eye of a rabbit. (*L'Union Pharm.*, p. 264.)

—A correspondent of the *Monthly Magazine of Pharmacy*, writing from Messina, says: "A bottle of bromine left in a closed room all night with the stopper out destroys all infection and insect life. I have cleared places which were infected with vermin many times. It is far more effectual than the vapor of burning sulphur."

—Dr. Peckholt, of Rio Janeiro, finds that the pulp of the cimaroma, a plant found both in the Brazils and in Spain, is valuable as a laxative, ten grains of the alcoholic extract being sufficient to produce an action of the bowels. Mixed with vinegar and water, it is used by the natives of Brazil for erysipelas.

—Dr. Austin Flint, jr., adds four more cases of diabetes to the fifty-two reported to the American Medical Association. The patients were placed on strict anti-diabetic diet, and Clemens' solution of arsenite of bromine, beginning with three drops, increased to five, was also given. Of these four cases, three were permanently relieved. In conclusion, he adds: "Diabetes has become to-day a disease easily and certainly curable, provided that the treatment be not begun too late."

—The very rapid death of a boy, aged 15 years, from the inhalation of sulphuretted hydrogen gas in its pure state, is reported from Irvine (Scotland.) He was engaged in a chemical laboratory there, and was assisting in carrying out some experiments. In the absence of the person in charge, he approached a boiler which he had been cautioned not to go near, because of the presence of this gas, and immediately he fell down insensible. Though he was at once removed to the pure air, and every effort was made, under medical supervision, to restore animation, he never recovered consciousness, and died in an hour.

QUERIES AND REPLIES.

MESSERS. EDITORS:—

My attention has been called, and opinion asked, as to the "Brinkerhoff treatment of piles, rectal ulcers," etc., by a party suffering with same. I know nothing of it. What is it? Is there anything in it? A SUBSCRIBER.

DEATH.

GIFFORD.—June 14, 1885, at Laurel, Ind., of paralysis, in the 70th year of his age, Dr. Thomas Gifford, a member of the Franklin County and State Medical Societies, of Indiana.